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## ORIGINAL DEPARTMENT.

### LECTURE.

#### RETROVERSION OF THE UTERUS.\*

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One of the commonest forms of displacement of the uterus is retroversion. It is not the most common, for it is very probable that prolapsus in its various degrees is of the most frequent occurrence. I wish to-day to make some remarks concerning this most important uterine dislocation, not by any means attempting to go over the whole range of the subject, but to touch on some of the more salient features of the disease, in its etiology, diagnosis, and treatment.

Retroversion, or backward displacement of the uterus, in the great majority of instances, is found in multiparous women; (not invariably, for nulliparæ are sometimes so affected,) as a result of parturition and conditions present in the lying-in state.

All displacements of the uterus are brought about by whatever increases its bulk and weight, whatever relaxes its support, whatever presses it out of position, and, finally, whatever pulls it out of position.

These are the four factors, in the main, operative in creating all kinds of displacements; the special kind, prolapsus, anteversion, retroversion, or lateroversion, being dependent upon the degree or intensity, the direction or combination, of these causative forces.

Now, there is no time during the life of any woman when these factors are so frequently and potentially operative as after par-

turition. At no time, unless from tumor, is the uterus bulkier and heavier than after delivery—even ten days to two weeks—the time when most women get up from the lying-in bed.

It takes from one to two months for the uterus to resume its normal size. Many circumstances—as injury to the soft parts by bruising or laceration, septic absorption, septic or non-septic inflammation, bad states of the general health—may delay these healthy, necessary, transforming changes in the uterus, and it remains an enlarged, heavy, very vascular organ, easily displaced, because of an incompetency of its supporting powers under an increased pressure. But, at this very time, the supports themselves are weakened. The vagina has recently been enormously stretched; it may be, torn. The perineum and the pelvic floor, which underlie the vaginal support, if not lacerated, may have been stretched. All the surrounding ligaments are relaxed—consequently weakened.

Under these circumstances you can readily appreciate how prone she is to a displacement of this organ. With perineal lacerations quite often do we find retroversion associated, directly or not, as cause and effect. The perineum may be torn back to and through the sphincter ani, and no displacement of any kind follow. None will follow unless other structures are at fault. These are an increased bulk of the uterus, and above all, a relaxed condition—a yielding of the pelvic floor. A firm, unyielding pelvic floor has more than aught else to do in maintaining the normal position of the uterus.

So much, then, for displacements in general. I will now refer to a few special causes which,

\* Abstract of a clinical lecture before the class.

in conjunction with the above, are active in developing retroversion:

1. The posterior wall of the uterus after parturition is, usually, thicker and heavier than the anterior—a condition which, during the involution processes acting in the line of gravity, aids the organ to fall backwards.

2. The posture of the lying-in woman. Usually, it is the dorsal, with the shoulders elevated, and the pelvic inclination so altered as to increase to the utmost the intra-abdominal and intra-pelvic pressure from above. This augments the blood supply in the hinder portion of the uterus, delaying involution there, and gives full play to the forces of gravitation in the backward direction.

3. The pernicious practice of adjusting an abdominal bandage with an underlying pad, tightened from day to day by the full strength of the nurse, while the patient is in the incumbent dorsal position.

4. Constipation—distension of the rectum with fecal accumulation, together with the straining efforts at stool to effect rectal evacuation, further stretching the pelvic floor and the utero-sacral ligaments.

Many of the worst cases of retroversion and retroflexion are associated with lacerations of the cervix. This accident brings about sub-involution, and occurs very generally when labor has been tedious and painful, and other soft parts have suffered injury.

In the comparatively few cases in which retroversion is present before delivery, it is coupled with retroflexion, and is generally congenital. Such a displacement may give rise to no disturbance, excite no suspicion of its existence, until some complication arises.

When retroversion exists before any pregnancy, it usually gives rise to no great inconvenience in the first few months of utero-gestation, although the backward movement at first is increased; afterwards (4th month), it rectifies itself. But, almost invariably, the displacement repeats itself and is rather aggravated during the coming lying-in state, to which reference has just been made. At the same time, I know from personal experience, that this time is an especially auspicious one to treat any woman for retroversion, with a view to prevent, or favorably modify, the old trouble.

There is no symptom or group of symptoms which is constantly found; none upon which any dependence can be placed in determining either the existence or kind of displacement.

Symptoms may or may not be present. The worst cases sometimes, though rarely, produce no discomfort, create no symptoms;

and vice versa, the greatest disturbance is at times noticeable when there is but a slight displacement. You may be surprised at this statement, but it is nevertheless true. The explanation lies in the fact that the symptoms do not arise so much from the *disorder of place*, as they do from the *disorder of circulation*, either antedating, co-existing, or following it.

There are many things with which retroversion can be confounded. Perhaps there is no more common mistake made in the diagnosis of female pelvic diseases than right here, in reference to conditions partly resembling retroversion. This displacement in its simplest form, uncomplicated, is very easy of recognition. The altered position of the cervix and the corpus uteri, the filling up of the posterior vaginal cul-de-sac with a rotund, hard body, which is usually movable, and capable of being dislodged by position and taxis: these are elements of diagnosis. But there are so many different diseases, as fibroid tumor, thickening of the posterior uterine wall from hyperplasia, chronic pelvic peritonitis, chronic pelvic cellulitis, pelvic hæmatocele in its after effects, extra-uterine pregnancy, etc., which create a like fullness and hardness to a certain degree, with or without a tenderness to touch behind the uterus, that by a little carelessness or ignorance, a mistake can easily be committed. Owing to imperfect histories and certain complications, such as the obscurities surrounding some cases, clearness in diagnosis is by no means easily reached. Some of these errors are much more frequently made than others. I know of none more so than the diagnosis of retroversion for chronic pelvic peritonitis, the uterine axis being normal, or nearly so—a very serious error so far as the welfare of the patient is concerned.

Before any treatment is instituted, the inquiry should be made: What has caused the displacement? Is the displacement the first disorder which has taken place in the case, or is the displacement but secondary to other conditions? Again, is the displacement complicated with other diseases?

The mere mechanical correction of the displacement may be a very improper treatment. Find out, if possible, what has been the primary link in the chain of the disease, and what is secondary, for almost invariably a number of conditions are linked together in a chain of morbid action, and the whole line is best broken up by taking hold of it in a certain order.

Retroversion, like the other uterine dis-

placements, is in most cases a secondary disease. It does not occur first as the result of an increased bulk and weight of this organ, coupled with some relaxation or weakening of its supports. In those exceptional instances in which the displacement is primary, it is doubtless the proper thing to do to correct it at once, by mechanical means, especially should there be resulting symptoms; but for reasons manifest in the great majority of cases, a different procedure is not only prudent but necessary, if we expect a permanent relief. For instance, if increased bulk and weight of the uterus are encountered with a displacement, correct the former first. The increased vascularity of the organ—a necessary accompaniment of increased bulk—is diminished by rest and leeching; better still, by puncturing, local applications of anhydrous glycerine, the hot douche, and occasional purgation. The long-continued effect of ergot in small doses changed in time to the administration of the mercuric bichloride in minute doses, is exceedingly beneficial. The bitter tonics, with nux vomica, are also very useful, improving the general and local circulation, and giving tone to locally relaxed parts. If the integrity of the parts—the perineum and pelvic floor—have not been too much destroyed by tearing or stretching, if the cervix uteri has not been much torn, so that a radical change in the structures of the uterus cannot be effected without a resort to operative measures, the means mentioned will often so improve the local condition of the uterus and the surroundings that the retroversion is either entirely corrected or so far improved that no special attention to it is required, and no further treatment is needed. In my own experience, this plan has so often succeeded in correcting or diminishing retroversion that I generally commence a course of treatment in this way. Should the perineum, however, have been much lacerated, the vaginal walls relaxed and displaced, the cervix torn, everted, and enlarged, an improvement can proceed only to a limited extent unless surgical steps are taken to repair damages.

The restoration of a lacerated cervix uteri to its normal shape, size, and circulation, by trachelorraphy, will have very much to do in improving the position of a malposed uterus. The repair of a torn, weakened perineum and vaginal walls, by perineorrhaphy and colporrhaphy, is generally absolutely necessary to bring about any decided and permanent change for the better in the position of the uterus.

Now, these and all other complications and antecedent conditions having received due consideration, we are ready to give the retroversion itself attention, provided it persists, and provided, also, it creates no discomfort, and does not interfere with the circulation or function of the surrounding parts and organs.

Now, as to mechanical supports. Before we think of them, we should see whether we cannot diminish pressure from above. With this object in view, the clothes should be tight and suspended from the shoulders. The bowels must be kept free from fecal and gaseous accumulation. It is highly absurd to attempt to prop up from below a displaced uterus, when it is pushed down by avoidable pressure from above. No abdominal bandage can be of any service in pure retroversion. The uterus cannot be lifted up by abdominal appliances; the most they can do is to lift off, to a limited degree, the intra-abdominal weight. The intra-vaginal supports are pessaries and tampons. The former may be called permanent, the latter temporary supports or splints to the dislocations. The former should never be utilized until the dislocated organ has been put beforehand into the best possible condition, by healing any erosions, checking catarrhs, diminishing weight, and strengthening the surroundings. Not so with the temporary support; for its use each time before insertion does not imply a complete rectification of the mal-position. With the tampon properly constructed, medicated, and placed, we have a means not only to temporarily hold the mal-posed organ *in situ*, but to alter its circulation and structure and remove its diseases. Its effects, then, are mechanical and medicinal. Many displacements are best treated by them at first; some need no other treatment. It requires some skill, acquired only by experience, to obtain their full benefits. In the displacement under consideration, after the uterus has been replaced (if possible) by posture and taxis, a broad, flat tampon made from absorbent cotton, saturated with an emollient or astringent lotion, as the case may require, is packed in the posterior vaginal cul-de-sac, to suspend the uterine body, and draw back the cervix; while another is packed in the anterior cul-de-sac to assist in the same movement. Treatment of this kind, repeated at intervals of once in three days, continued for several weeks or longer, accomplishes a great deal of good. In conjunction with the use of a vaginal douche during the intervals, and appropriate general medication, it may be all that is required. Repeated reposition, al-

ways gently made, and well-nigh continual support with the tampons, gradually do away with the structural faults in the uterus itself, enable the natural supports to regain their former strength, and bring about a return to normal position, which may be permanent.

I think very highly of this class of treatment in cases of retroversion, with or without flexion, in which from long-continued malposition or otherwise, the uterus has become fixed by adhesions to the rectum, and immediate reposition (unless great force is employed) is impossible. The repeated use of these tampons, continued for some time, will, by degrees, soften the para-metric adhesions, put them on stretch, break them down in a way which is perfectly safe, and gradually make the uterus mobile and reducible. Yet how often we see patients so afflicted treated by a pessary! Would it not be just as rational to apply a splint to a non-reduced fractured bone?

A word as to the use of the sound to reduce dislocations of the uterus. The sound should not be used if we can possibly succeed in replacing by posture and taxis. The sound should not be used if there is the least suspicion of pregnancy. Careful inquiry should always be made in reference to the menstrual history. It is practicable to reduce any dislocation of the uterus, even when adherent, it matters not how long standing; but it is not prudent to do so. The practice is hazardous. It is by far a better plan to gradually stretch and soften the adhesions, as before suggested, than to resort to force. But there are cases and conditions suitable for the employment of this instrument. When posture and taxis have failed, and when the uterus is impacted under the promontory of the sacrum, but is not tender to touch, and will bear the manipulation, then we may carefully use the sound. I prefer it to all those contrivances which are called uterine repositors. The following is the method: Introduce the instrument properly curved within the uterus to the fundus. Change the relation of the concavity and convexity of the shank by rotating the sound, not by suddenly twisting the uterus upon itself, but by keeping the uterine extremity as stationary as possible, and revolving the manual extremity over an arc of 180°, the sweep of which is as large as the vagina and vulva will permit. When done, depress the handle against the perineum. By this method there is little or no injury done the uterus, and hence a minimum of pain.

We cannot dispense with pessaries in the

management of some displacements, principally retroversion. They are a necessary evil. Properly constructed, accurately adjusted, in well-selected cases and conditions, they are capable of giving great comfort, and doing much good. To a very great extent the bad repute in which they have been held by some, is owing to their misuse.

The class was then shown three cases of retroversion, their histories read, and treatment given.

## COMMUNICATIONS.

### PYÆMIA OR BLOOD-POISONING.

BY CHAS. P. KING, M. D.,  
Of Newark, O.

The subject to which I invite your attention for a short time is that of pyæmia or blood-poisoning, and in presenting this paper for your consideration, I beg leave at the outset to ask your kindest indulgence for its deficiencies, on account of the shortness of time allowed me for its preparation. The subject is one of exceeding interest, the literature of which is both rich and extensive.

It would be pleasant to present you with a full and comprehensive resume of it in numerous and valuable studies, but the character of this paper forbids.

The fact that some injuries and operations are occasionally followed by the development of abscesses in some one or more of the internal organs of the body was brought to the attention of some of our older surgeons. The subcutaneous tissue and joints are the most frequent seats of these abscesses. Sometimes they affect the lungs and other viscera. Ambrose Paré, the great French surgeon, makes mention of it, and his observations were afterwards confirmed by those of Morgagne, Larry, Guthrie, and other military surgeons of continental Europe. Velpeau, however, was the first surgeon we have any knowledge of who investigated the lesion in a really scientific manner, and who turned the attention of the profession to a most thorough and elaborate examination into its etiology, pathology, and treatment.

These observations were given to the world in 1823, a little more than half a century ago. Previous to that time but little was known as to its real pathology.

Pyæmia literally means pus in the blood, or in other words, a condition in which there are pus-cells in the blood; but the expression is known and now considered as imply-



ing that the blood is altered throughout the whole system by the previous action of putrid animal substance in the form of gases, fluids, or solid particles, which so distort its relations with the living tissues as to induce coagulation of the fibrin of the blood, in some part during life, within the blood-vessels, associated with fever and the formation of local abscesses in one or more of the viscera and other parts, and usually accompanied with phlebitis.

How then, the question may be asked, does pus enter the blood, and what is its physiological action upon the tissues? It will be my purpose to endeavor to answer the above question with fever and the formation of this subject.

Pus as pus is never taken up or absorbed into the system. Its fluid parts only may be absorbed by the veins and lymphatics, but the solid portion remains as a thick, concrete mass, and thus the absorption or disappearance of an abscess gives rise to such "cheesy" products as are described by the name of "*tubercle*." Again, pus may be completely absorbed, but only after the cells have been reduced to a state of milkiness by fatty degeneration, and become converted into an emulsive mass. The composition of pus varies very much, and the conditions under which it varies have not received that attention which its importance demands. It seems to vary with the locality whence it is formed. Says Prof. Aitken, "*Pyæmia as a specific original entity, a result of absorption of pus as such, is not now believed in, and any evidence of such an event daily becomes less and less.*"

Pyæmia is now regarded as a collective name for many different diseased processes, just as the essential phenomena of Bright's disease are brought about by several different morbid conditions of the kidneys. Hence the word pyæmia literally signifies, according to one of our most modern authors, "An alteration of the blood by pus, or perhaps, more properly speaking, by admixture of the two fluids, giving rise to what has been called septicæmia or purulent infection."

"Absorption of pus as pus" through the walls of the blood-vessels having been shown to be impossible on account of its cellular nature, the pus-cells being too large to pass through the capillaries, other theories are now advanced. Under the name of pyæmia several affections are included:

1. Septicæmia, that is, blood contamination from absorption in a liquid state of putrescent or otherwise morbid material.

2. Transfer of actual pus by veins in case of phlebitis, and its deposit in new localities.

3. Thrombosis, or coagulation, in a vein during life, followed by embolism, or the conveyance of a portion or portions of coagula, to different parts of the body, causing irritation and obstruction.

The exciting causes of pyæmia or blood poisoning are numerous and varied in their character. They may be stated in general terms to be such as are productive of great shock to the system, loss of blood, and depression of the vital powers.

The symptoms of this disease are chills, profuse sweats, low fever, rapidity and feebleness of pulse, great prostration, debility, and swelling of the joints. Death may occur in a few days from devitalization of the blood. The symptoms may be of gradual development, but oftener they set in suddenly with a chill, to which fever of a low type soon succeeds. The prognosis of this malady is most unfavorable; few cases recover, and these, for the most part, remain in a debilitated condition, liable to attacks of disease from the slightest cause. Of over forty cases, mostly gun-shot fractures, treated at one of the leading hospitals after the battle of Gettysburg, all died. During a practice of some seventeen years I have seen but four genuine cases of pyæmia, or blood-poisoning, all of which proved fatal. Death in these cases usually occurs within a week or ten days after the commencement of the malady.

As to the real nature of the poison of pyæmia, we know comparatively nothing. We only know it by its effects upon the human body. The poison, whatever it may be, is most virulent in its character, and it is one of the worst foes the surgeon has to contend with in his treatment of certain kinds of wounds. That certain constitutions are predisposed to it, is unquestionable, as it follows in some injuries of a most trivial character; this fact was demonstrated during our late civil war. I would like to discuss at length the various theories advanced by pathologists as to the manner in which pus is absorbed into the blood, but the scope of this paper forbids.

The doctrine advanced by the eminent Prof. Bennett, of Edinburgh, is probably the one now accepted by the profession at large. He accounts for the formation of purulent deposits by supposing that they are caused by the development of a peculiar poison derived from certain kinds of pus, which entering the blood, contaminates the circula-

tion and solids, and thus brings about that atonic condition of the system so characteristic of pyæmia. According to this doctrine, pus corpuscles do not enter and mingle with the blood; what has been taken for these bodies by various observers being the colorless cells of the blood, the distinction between the two being often extremely difficult, if not impracticable. Says the eminent Prof. Gross in his immortal work on surgery: "Agreeing with its advocates that it is impossible for pus corpuscles as such to enter the blood, except in the case of open-mouthed veins, communicating with a suppurating surface, I think it perfectly certain that the more attenuating and watery parts of pus, or, perhaps, more commonly speaking, the more ichorous, sanious, or sanguinolent varieties of this fluid, become commingled with the blood in suppurating wounds, and in the stumps of amputated limbs, thereby speedily and thoroughly contaminating both solids and fluids, and consequently effectually undermining the constitution, thus resulting in pyæmia or blood-poisoning."

*Treatment.*—As to the treatment of pyæmia but little need be said. Since the introduction of antiseptics in surgery by the eminent Professor Lister, of London, the death-rate from capital operations has been very materially diminished. Blood-poisoning arising from altered secretions in the wound, which has hitherto been the ever present dread and danger, is prevented. If this is owing to putrefaction, which depends upon the admission to the wound of the minute living particles, and if by the careful application of certain precautions these changes and their consequences may be with certainty prevented, then all these various forms of septic and pyæmic processes may and should be eradicated. This broad antiseptic method gives scope to a great variety of detail, which I hope to consider at some future time. Among the best known antiseptics are carbolic acid, salicylic acid, thymol, bichloride of mercury, and Listerine.\*

In our treatment of blood-poisoning support and depuration of the blood are the main

indications; of medicines, many have been advocated, but the profession have been disappointed in their results. Of these, we might mention the sulphates and hyposulphites of lime and soda, magnesia, and carbolic acid as an antiseptic. Dr. Bell, of Edinburgh, reports three recoveries with hardly any remedies. He gave milk, with lime-water, eggs, and beef-tea at short intervals. A general supporting treatment is indicated in every case. Quinine in large doses is advocated by some, and no doubt will do good in some cases. Dr. John Wood advocates saturating the air around the patient with carbolic acid by hanging materials containing it near the patient. This plan was carried out in the case of the lamented President Garfield. This is an admirable remedy where the patient is confined in a close room, where the air is not fresh and pure. Good nursing and attention to the surroundings of the patient are very essential. Disinfectants should be used from the very commencement of the attack. The eminent Dr. Paget says: "The exposure of the patient to currents of fresh air is most promising of success in cases of pyæmia."

The treatment of this disease is much better understood than formerly, and as a result the death-rate has been somewhat diminished.

Notwithstanding all this, we have yet much to learn as to the true nature of this disease, and until the pathology of pyæmia is much better understood than it is at the present time, it will continue to be, in the future as in the past, one of the worst foes with which the modern surgeon has to contend. In the light of the present century, when such rapid strides are being made in almost every department of science, we have every reason to hope at least that ere another decade shall have elapsed, some more subtle power even than the microscope will have been discovered, which will give us the power of scrutinizing more closely diseased conditions, and of finding out the agents which are so stealthily at work bringing the human machine to misery and premature death.

\*At a recent meeting of the Philadelphia Academy of Surgery. Dr. R. J. Lewis, of that city, read a communication entitled "New Antiseptics, Hydronaphthol, and Potassio-Mercuric Iodide." The claims made for the newly-discovered antiseptic hydronaphthol are that it is at least twelve times as effective as carbolic acid, thirty times as potent as salicylic acid, sixty times as effective as boric acid, and has six hundred times the antiseptic power of alcohol. As an antiseptic, it ranks next in importance to the mercuric bichloride. The potassio-mercuric iodide is four or five times as powerful as a true germicide or disinfectant as the mercuric bichloride. For such use it is effective in aqueous solutions in the proportion of only one to twelve thousand. The introduction into surgical practice of these two powerful substances will do much to overcome some of the ob-

jections and inconveniences of antiseptic practice. The profession owes a lasting debt of gratitude to Dr. Lewis for having brought this subject to their notice in so practical a manner. Bisulphate of carbon, Pasteur, the great French scientist, thinks will become the most efficacious of all antiseptics, as it is also the cheapest, costing but a fraction of a penny per pound in large quantities. It is besides the best insecticide known, and for this purpose it is thought may be useful in preserving wood-work in tropical countries. Some idea of the use of it may be gathered from the fact that more than eight million pounds of the substance are sent annually to check the ravages of phylloxera. Bisulphate of carbon is produced through an offensive compound in respect to odor, but is capable of purification.

# THE INFLATION OF THE EUSTACHIAN TUBE IN AURAL CATARRH OF YOUNG CHILDREN.\*

BY LAURENCE TURNBULL, M. D.,

Aural Surgeon Jefferson Medical College Hospital, Phila.

In reply to a letter desiring to be informed as to the mode of the use of a tube to inflate the Eustachian tube by the mother, I must first state that her physician must be sure that the cause of deafness is an exudation of pus, mucus, or serum into the middle ear. If the child has had an earache, and there has been a perforation of the membrana tympani shown by a discharge, in this case the simple act of blowing the nose will open the tube; this act should always be taught the child.

If the child is too young to perform this, the nose must be cleansed several times a day with a soft camel's-hair brush, or small syringe and warm water, with a few grains of bicarbonate of soda, that will assist in opening the tube. If, however, there has been inflammation of the middle ear of the child, the result of a cold from a naso-pharyngeal catarrh, acute exanthema, or pneumonia, attended with pain in the ear, or if the acute symptoms have been relieved by leeching, hot water applications, chloroform vapor, etc., the child recovers without perforation, but is deaf. This deafness is apt to be overlooked in the beginning, even by the parents, and the child is sent to school, where even a very moderate degree of deafness is very soon detected, and the child is stated to be absent-minded, or has the bad habit of asking twice the same thing.

This inattention is very often due to an abundant secretion behind the drum membrane and the closure of the tube. There may be no very decided pain in the ear, but only a heavy feeling in the region of the ear or in the head in general. (We cannot at this time enter into the diagnosis and treatment of acute and chronic aural catarrh, but would refer those who are interested to chapter iv. of our work, under the title of "Artificial Perforation of the Membrana Tympani, and the Removal of Organized Material from the Middle Ear.")† This secretion is usually liquid or semi-solid, and if it has remained for a long time becomes dry. We must provide an outlet for it, and one of the quickest is paracentesis of the drum-membrane; but this is only necessary in severe scarlet fever or diphtheria and in older children.

\*The above was prepared in reply to a query from one of our readers.—EDS. REP.

† Imperfect Hearing, 3d ed., J. B. Lippincott & Co., Phila.

We have in Politzer's inflation a valuable means of diagnosis and treatment, by which we can determine if there is fluid in the middle ear by placing the diagnostic tube in the child's ear, while we inflate through the nose and listen for the thud or normal or abnormal moist sound: this latter will make the diagnosis certain. This operation of Politzer's consists in a condensation of the air in the naso-pharynx, by a strong inflation into the cavity, while the nostrils are closed with the fingers. In the case of adults, it is necessary that they should at the same time swallow, in order that the raised palate may close the naso-pharynx behind, and also because the act of swallowing opens the Eustachian tube, and thus furnishes a passage of air into the middle ear. In children, however, this swallowing is not absolutely necessary, because the naso-pharynx is so small that the condensation of the air is greater than in adults, and because also the tubes are in children relatively wider than in adults, and the action of the compressed air can therefore more readily reach the ear.

Children in whom this method of inflation is employed, as a rule, contract the muscles, and so unconsciously raise the palate. Instead of the rubber bag for the air, as is generally used, with hard long nozzle to be inserted back into the nose, a short rubber tube is what I use, the two ends of which are furnished with a quill, bone, or ivory termination, one for the mouth of the physician, nurse, or mother, the other for the nose of the patient. After cleansing the nose by gently blowing, washing, or wiping it out, the end is inserted and kept in place with the finger and thumb, and with the other end a blast of warm air is blown into the middle ear. At first the little patient is frightened, and grasps both at the instrument and ear; but after a time he gradually becomes accustomed to it, as it gives no real pain, and it becomes rather a source of amusement. Any intelligent mother or nurse could practice this operation when so ordered.

1502 Walnut st., Phila., Feb. 22, 1886.

## HOSPITAL REPORTS.

### PHILADELPHIA HOSPITAL.

SERVICE OF DR. L. W. STEINBACH.

#### Hydrocele.

Feb. 10. These apparently trivial cases are really those which you will most frequently be called upon to treat, hence it is well that you should see them. This man came into

the hospital two days ago, and you see that he has a very large scrotum; it is in fact a hydrocele, which I will evacuate and inject the sac with carbolic acid, which I prefer to the tincture of iodine. The acid quickly benumbs the part, and a moment after the injection the patient feels no pain. Before injecting the acid, you will note that I smear the whole scrotum about the site to be punctured with cosmoline; this I do because if I did not take this precaution, and any of the acid should drop on the scrotum, it would burn it quite severely. I make it a rule to let these patients go about immediately after the injection, but confining them to bed on the second or third day, when the induced inflammation sets in, for exercise, at this time, may cause an undue degree of inflammation. I use pure carbolic acid, simply the deliquesced crystals, injecting from one to two scruples. Before injecting I grasp the scrotum and render it tense by pressure; then I lay my trocar and canula along the course of my index finger, and by a rotatory motion work the trocar in. You must always look out that you do not wound the testicle. I make it a rule when the accumulation is very large to evacuate it, allow it to re-accumulate, and evacuate again before I make the injection of carbolic acid, because by this means the surface to be cauterized is considerably reduced in extent. Now, when I have withdrawn the fluid I find the testicle large and hard, and upon inquiry I find that the young man had gonorrhœa some years ago; this condition does not, however, contra-indicate the injection of carbolic acid. When I have injected, I endeavor by manipulation to bring the acid thoroughly into contact with the tunica vaginalis; the pain, as I have said, is only momentary.

#### Stricture of the Rectum.

This girl, Eva F., is twenty-four years old; she is married, has had two children and no miscarriages, and says she has leucorrhœa, but has never had syphilis. She has been a drinking woman, but was perfectly well until October, 1883, at which time she suffered from diarrhœa, tormina, and tenesmus; she experienced great pain with each act of defecation, and suffered from headache and backache. Upon examination we found that she had a stricture of the rectum, which was located just a short distance within the sphincter. The fecal discharges are thin, watery and offensive. When a patient complains of diarrhœa, dysentery or constipation, which persists without a good cause, you should always examine the rectum; it is a false modesty that holds us back from mak-

ing these examinations. There is an expression of countenance that is somewhat peculiar to disease of the rectum, and that should cause us to suspect its existence; I might speak of it as an expression of great distress. When we find a stricture low down in females, it may be due to the extension of an inflammation from specific sores, causing a sub-mucous deposit and contraction. Epithelioma is not an uncommon cause, especially when we find the stricture about a finger's length within the sphincter. Simple ulcers or pelvic cellulitis may also serve as a cause, but cancer is the most common cause. Well now, when we proceed to dilate these strictures, the Sims' position is the best, the knee-chest position, but we can manage very well if she lies on her side. You see, before introducing my finger into the rectum, I fill the space between the finger and the nail with soap, which is a practical little point well worthy of your attention. It prevents the risk of wounding the bowel with the nail, and at the same time saves you from the danger of infection. When we find the anus patulous, as it is here, we are likely to find the stricture some distance above the anus; now, when I introduce the finger as far as I can, I find a simple narrowing of the calibre of the gut, but I do not feel any nodules or any exudation; the stricture is not tight. In these cases, when taken hold of early, something very like a cure can be effected by gradual dilatation; if not seen until late, the condition may be palliated, but we cannot hope to do as much as when we see them early. This woman's feces are tape-like, and we should keep them soluble. The digestive system always suffers more or less in these conditions, and this derangement must be attended to. Remember, when introducing your dilators, the direction of the rectum, and always pass them from behind forwards, being careful never to use any force. This instrument, as you see, passes up readily, so I know that there is no stricture beyond that which I can reach with my finger, therefore I feel that this is a promising case. I am here using soft flexible bougies; some prefer using candles.

February 17. I wish to show you the case of hydrocele, upon which I operated last Wednesday. Now I feel a hard, irregular, nodulated swelling, which is due to the effusion of lymph, caused by the injection of carbolic acid. In time this will disappear and we will have the scrotum of its normal size. I would say that, as a rule, it will take about two months for this effusion to disappear.



**Burn.**

Here we have a burn that occurred nine weeks ago, and you see this granulating tissue; there are gelatinous masses with vessels around them—this is embryonic tissue; then we have formed cicatricial tissue, which is another step in the process of granulation; the embryonic cells become connective tissue cells—and cicatrization, remember, always commences at the edge of a wounded surface. These granulations are too large and florid, and bleed very easily; so I am going to hasten the healing process here by skin-grafting. It is always a wise precaution to take the grafts from the individual, as by so doing we avoid any possibility of infection. When skin-grafting first came into vogue, large pieces of skin were used, but it was subsequently found that they did no better than small ones. After a while the epiderm macerates off from these grafts, and unless you are prepared for this you may imagine that your grafts are not going to take; but the true derm remains, and this is all you want. Now I take an ordinary cambric needle and transfix the smallest possible piece of skin on the arm with it; then I pass scissors under the needle and nip off this minute piece of skin; I am careful to get the under surface of the graft applied to the ulcer. In former times it was the custom to make incisions on the surface before applying the graft, but it was found that the blood so drawn was really an impediment to the success of the operation, and it was abandoned. After placing these grafts in position I will allow the surface to remain exposed for an hour, so that the plasma exuded may fix them in position before I apply any dressing. After several days, if the grafts take, I will note a slight blue pellicle. It is, of course, possible that none of these grafts may take, or it may be that some will take and others will fail.

**Fistula in Ano.**

My experience tells me that this condition is most common in those of a strumous diathesis. You may have an inflammation of the glands about the rectum, and when the discharge comes exteriorly, and also from the anus, it may be the first indication you have of a fistula. The usual seat of the internal opening of a fistula is just within the anus, near the margin of the junction of the skin and mucous membrane; this is an important point to remember, because the inner opening is not infrequently overlooked, because it is looked for too high up. When deciding upon an operation for fistula, I would say that we

should never use the ligature; incision is not dangerous, and is nearly always successful. Sometimes, when we have multiple external openings, we must lay them all into one.

**HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.**

SERVICE OF D. HAYES AGNEW, M. D.

**Sarcoma.**

This patient I have only seen since he came in a short time ago. He is forty-four years old, and says that two years ago he first noticed a little swelling on his right side; that is, he first commenced to experience discomfort from it at that time, though it may have existed before. Such is the history we not infrequently get of carcinoma of the breast, the disease no doubt existing for some time prior to the date at which it first attracted attention. This swelling is oblong and seems to occupy about half of the abdominal cavity; the abdominal walls are resistant, and upon percussion I get very little resonance. He is losing flesh, suffers much pain, and has a cough. Upon examination I find a little trouble at the apex of the left lung. Grossly speaking, the urinary secretion is normal. Posteriorly there seems to be no evidence of trouble that I could refer to the kidneys, but I caution you always to look very carefully before you commit yourself to such an opinion. Renal cysts will offer a condition very much like this, only that they will not be quite so hard. Judging from the age of the patient, the rapidity of growth of the tumor, the cough, and the loss of the flesh, I would infer that this is a sarcoma. Of course, in such a case, an operation is not to be thought of; we can only look to endeavoring to improve the man's general condition. I would suppose that this sarcoma was located in the right iliac fossa.

**Inverted Toe-nail.**

The next case is of an apparently trivial nature, yet it is well that you should know how to intelligently manage such a case. Inverted toe-nails are of very frequent occurrence; it is not truly that the nail grows into the flesh, but owing to some irritation there is an inflammation and proliferation of the soft tissues, which then bulge up around the nail and bury it. Want of cleanliness will act as a cause, the dead epithelium remaining about the toe acting as an irritant, but it is most frequently caused by a bad-fitting shoe. So also the majority of persons cut the nails wrong; it is a mistake to round off the corners—the nail should be cut

squarely across. Now I desired to show you this case because I think in the very large majority of cases a mistake is made when the nail is removed; there is scarcely any case that cannot be relieved by patience and perseverance; by patiently inserting some lint or cotton beneath the nail and patiently making pressure on the elevated skin so as to reduce it. Of course, there are some cases where this cannot be done and where we must remove the nail. The case before us is one in point; here the nail disables the young man for work, and he cannot afford to take the time to lay off from work for the conservative treatment. I consider this to be the most painful operation in surgery, hence you must always etherize the patient. When the patient is thoroughly anesthetized, I take a probe-pointed curette, and with it separate the matrix from the nail, when, with a pair of forceps, I draw it out. Sometimes, when the nail clings very tightly, it may be necessary to split it before we can remove it. After the nail has been removed, we will cover the raw surfaces with oiled lint or poultices for two days, after which we can use any kind of an ointment. Another nail, growing in place of the one removed, will be very apt to assume the same deformity as its predecessor, hence we must be very careful from the first to obviate the cause. Sometimes when the nail has been very greatly deformed, it may be well to destroy the matrix, so that another will not grow; when we wish to do this, we can pare around and cut out the matrix, and then apply caustic potash and dress with carbolyzed lint. In this latter event, a dense fibrous tissue will take the place of the nail, and will serve as a very fair covering for the toe. When you intend to save the nail, take a flat probe, and commencing at one edge, gradually work cotton under the nail, then make pressure on the flesh by means of a compress and adhesive plaster. I am frequently in the habit of making this compression with a piece of cork cut wedge-shape. I say, therefore, that it is only in exceptional cases that you are justified in removing the nail.

#### **Senile Purpura.**

You will occasionally encounter persons who will present a mottled appearance of the legs and feet, always in advanced life. They will be purplish, and there will be an indefinite dusky redness. There is no ulceration and nothing wrong with the kidneys in this case, which is a point to be noted, because such eruptions are not uncommon in persons suffering from Bright's disease or diabetes.

But, though there may be no ulceration, there is usually some change in the arteries; they are atheromatous, and are, in consequence, disqualified from properly regulating the circulation, so that these vessels become unnaturally distended and a slight leakage occurs from them into the cellular tissue. It is really more than an edema, it is an escape of lymph, which becomes more or less organized. This condition will sometimes cause great suffering in old persons, and will call for remedy. We must keep up the strength of the circulation in such cases, by giving carbonate of ammonia, and support the limb by an elastic stocking or roller. This will cause some absorption, but we must be careful to remove the bandage each day, because it will cause a sweating that, if confined, may irritate the part. This leg, I am quite sure, will look better in one week, under this treatment. These cases sometimes terminate in gangrene.

#### **Adenoma.**

This man has some kind of an enlargement behind his little finger on the left hand. He says that it dates back for only three or four months, but I think he must have had it for a longer time. You have seen burse on tendons, the contents of which is so much like calves-foot jelly. These burse are not common in this situation; I am not sure that it is a ganglion, but I think it is, for other kinds of tumors are rarely found on tendons. The consistency of this swelling warrants me in removing it with antiseptic precautions. Remember that the sheaths of tendons are very intolerant to interference, especially to open operations, so that, insignificant though the operation may seem, we will keep this patient in the hospital and dress his wound here. Now, when I remove it, I find that it is not a bursa, it is a solid tumor, made up largely of fibrous tissue and fat. I removed it without opening the sheath of the tendon; it was fed by one artery, which I ligate. This is an unusual location for an adenoma.

#### **SERVICE OF DR. JOHN ASHHURST.**

##### **Green-Stick Fracture.**

Here is a boy who fell down stairs and sustained a green-stick fracture of the forearm. The fibres of the ulnar on one side are broken, but not on the other. You know that this term is derived from the resemblance which such fractures bear to the condition of a green limb of a tree when you break it. All fractures begin in the line of extension, to use a term employed by

mechanics, the line of flexion is where the blow is struck. As I say, the fracture begins in the line of extension, and if the force has been great enough the fracture extends through the bone, but if not strong enough, it only extends through the line of extension. These partial fractures are apt to be overlooked, not so often in the forearm, but quite frequently when they affect the clavicle. A child may fall and strike on the shoulder. No symptoms are presented save pain when the neck is touched or moved, and, possibly, some slight depression. It may be supposed to be only a bruise, while in reality the clavicle may be broken. It is important that we should look carefully for such fractures, for if we do not recognize them, the chances are that they will be made out later on, and this discovery will not redound to our credit. Some authorities advise us to make gentle pressure in these cases of green-stick fracture, and leave the rest to nature; but I have seen considerable deformity result from this practice, and I think it is better surgery to convert the partial into a complete fracture by forcibly straightening the limb. I think it is best in all fractures of the radius, save in Colles' fracture, to use two straight splints. They should be long, commencing below the end of the elbow and extending to below the ends of the fingers. The posterior splint need not be so long, extending from below the olecranon to the back of the hand. If the long posterior splint is applied very tightly, it will cause pain and excoriation, but if you do not apply it rather tightly, it will be bulky and will be apt to lose its place. Be careful not to have these splints too wide; this is a very common mistake. I do not think it is necessary to use an interosseous pad. In all fractures of the radius it is of importance, in view of the future usefulness of the arm, that it should be kept in a supine position while the reparative process is going on. This point is not enough noted. If the arm is left straight, or, still worse, in a prone position, it will be found that when the fracture has united the power of supinating the arm has been lost. Such an arm as that before us should be kept in splints for at least three or four weeks. You had better err on the side of caution, for it would be very embarrassing to have the same bone refractured shortly after you had taken it out of the splints.

#### Fistula.

You know, of course, that you may have complete or blind fistulæ, but in either case

you must lay them open. *Fistulæ* are most commonly caused from injury, though they may result from cold, causing an abscess. Accumulations of fecal matter are very likely to cause internal fistulæ that have no external opening, especially if with the accumulation there be associated a stricture of the rectum. We may have a stricture of the rectum sufficiently open to admit the finger or a bougie, yet it will cause trouble by interfering with the peristaltic action of the bowel. That the bowels may be properly evacuated, just as with the emptying of the bladder, there must be a consensus of action on the part of all the muscles employed therein, and a stricture will interfere with this harmony of action. Well, then, this accumulation will irritate the mucous membrane, an abscess will form, and a fistula will result. When you find a number of fistulæ, you have a right to suspect some underlying condition, as a stricture. Again, when you find a stricture, always look above it for the internal opening of the fistula. When we have a stricture, we cannot hope for a perfect and permanent cure of the fistula unless we relieve the stricture. It is a serious and troublesome complication, but does not render the case necessarily hopeless. In some cases, when it is low down, we may divide the stricture, using the galvano-cautery, the knife, or the actual cautery, or we may cut the fistula and gradually dilate the stricture. To cut the stricture. I must caution you, it must be low down; it would not be safe to do so if it were high up.

### MEDICAL SOCIETIES.

#### OBSTETRICAL SOCIETY OF PHILADELPHIA.

(Continued from page 273.)

Another cause of tardy first stage of labor is

#### Premature Rupture of the Membranes.

This accident is apt to interfere with the progress of labor in the stage of dilatation by the absence of the dilating cone formed by the membranes in normal cases, and by direct contact of the presenting part of the fetus with the uterus. Owing to the former, the uterine force is exerted at a disadvantage; and by the latter, the os is apt to become rigid, dry, and sensitive, while the mother's suffering is much increased. The fetus is exposed to exceptional risk when obliged to pass through the entire stage of

dilatation of the os without the protection of the liquor amnii, for not only are its parts subjected to injurious pressure, but owing to the much greater degree to which the uterus can contract, the interruption to the supply of maternal blood to the placenta is much more complete. Yet it is possible for the fœtus to retain perfect vitality for many days after the escape of the liquor amnii, as is shown in the following cases:

Mrs. M., æt. 38, sent for me in June, 1878. I found her pregnant with her eighth child. She was in a state of great anxiety on account, as she asserted, of the escape of the waters, which she told me had come away in large quantities. Examination did not convince me of the accuracy of her statement, and I concluded she had mistaken the source of the aqueous flow. One thing was certain, however, and that was that she was not then in labor, although very near her time. She was enjoined to keep quiet, though rest in bed was not insisted upon. Five days afterward I was again sent for, and found her in the first stage of labor, but no membranes could be felt. She was safely delivered of a living child. If the membranes really did rupture at the time supposed, this is the longest period between the rupture of the membranes and the coming-on of labor I have met with personally; but the following cases represent the possibility of the preservation of the vitality of the fœtus under these unfavorable circumstances for a much longer period:

Dr. Matthews Duncan reports a case in the *Lancet* for June 29, 1872, in which forty-five days elapsed from the time of the rupture of the membranes to that of the birth of the child. During the whole of this period the liquor amnii continued to escape as it was secreted, and the size of the uterus, as felt through the abdominal walls, was greatly diminished. When labor took place a seven-months' fœtus was born, and lived for several hours, although much deformed by the protracted pressure to which it had been exposed.

In the *Medical Times and Gazette* for September 18, 1852, Dr. John Gould reports a case in which twins, a boy and girl, were born living five weeks after the waters had come away.

Although the above cases are well authenticated, especially that of Dr. Duncan, in which the most careful observations were made, yet the asserted escape of the liquor amnii must be always received with great caution. The sources of the aqueous flow which may be mistaken for the liquor amnii

are numerous. The spontaneous escape of urine is not infrequently mistaken by the patient for that of the liquor amnii, while the flow of profuse secretions of Cowper's glands; the rupture of a cyst of the chorion; of another developed or undeveloped ovum; of a cyst lying between the chorion and the amnion, may prove the source of the supposed liquor amnii. That the membranes may again close after having been ruptured has been proven. This is not accomplished by a process of healing, as was at one time supposed, but by the sliding of the different layers of which the membranes are composed upon each other, by which a small opening may be effectually closed. After closure of the amniotic cavity in the manner described, the liquor amnii again collects, for this fluid is continually secreted, as first shown by Winkler and demonstrated in Matthews Duncan's case.

A source of error in diagnosis as to the origin of the flow is in rupture of the membranes at a point within the borders of the os and out of reach of the examining finger. Here vaginal examination shows the presence of the membranes closing the os and which become tense during the pains, while the opening becomes patulous and admits of the escape of the liquor amnii during the periods of relaxation. Notwithstanding the occasional occurrence of cases such as I have just given, the usual result of the escape of the waters, at whatever period of gestation it may occur, is to precipitate immediate labor; and this labor, as already shown, is unusually distressing to the mother, and at the same time subjects the fœtus to increased risks. We have seen that the peril to the fœtus is due solely to the persistence or the frequency and violence of the pains interrupting too frequently, too persistently or too completely the supply of maternal blood to the placenta. The abnormal pains are not alone due to the irritation of the mouth of the uterus by the direct contact of the fetal parts with the uterus, but also to the mental condition of the woman. Most women view the occurrence of rupture of the membranes at the beginning of labor with anxiety and alarm; and such a state of the mind is very apt to be reflected injuriously upon the action of the uterine muscles. Hence, care is necessary in the conduct of such labors; first of all, to reassure the patient, then to enjoin rest as soon as the pains come on, and if they are at all disposed to assume an abnormal character, to keep the woman constantly in bed and give opiates to control the severity of the pains, to preserve



the proper rhythm of the contractions, and to favor dilatation of the os.

Before closing this paper I wish to refer to another though kindred subject. I allude to the obscure symptoms sometimes occasioned in parturient women by the presence of intercurrent acute disease. I have several times been deceived by symptoms due to the malarial poison becoming manifest during labor or in the lying-in period, which have in the one case closely simulated approaching exhaustion, and in the other acute local inflammation. Sometimes the manifestations of the presence of this poison consist of chills followed by fever, while in other cases there is more or less severe neuralgic pain alone. When the previous history of the patient has been obtained, and such history shows the presence of the malarial poison, the diagnosis of the true nature of the symptoms is not difficult, but it is so when no evidence of previous symptom of intermittent fever is attainable. The following case is one of this character:

Mrs. C., æt. 22 years, was taken in labor with her first child early in the morning of June 8. As she had been referred to me for attendance in confinement by her regular medical attendant, I had no opportunity of obtaining a personal knowledge of her previous health. I learned, however, that in so far as she knew she had never suffered from malarial poisoning. She had, however, suffered very much from almost continuous nausea and frequent vomiting at the beginning and toward the close of her pregnancy. The labor continued throughout the day, and in the evening became quite severe. The vertex presented in the first position. As the os dilated but slowly, and the patient's sufferings were severe, I ordered her to take a full dose of morphia. An hour or two later her symptoms were not satisfactory; her pulse was beating at the rate of more than 100 per minute, her mouth showed a tendency to dryness, constant thirst existed, and the patient frequently vomited bilious matter. Although the uterine contractions were very painful and frequent, they were short, weak, and inefficient. When the patient had been over twenty hours in labor, as the os was pretty widely dilated, I decided, in view of the symptoms, to apply the forceps and establish the second stage of labor, believing the physical strength of the patient to be sufficient to safely accomplish the subsequent stages of delivery. She was accordingly etherized to complete unconsciousness, and the head of the child brought through the os and down upon the floor of

the pelvis. The forceps was then withdrawn. As the effect of the ether passed off, good expulsive pains came on, and in due time a living child was born without accident. The mother did well for the first nine days after delivery, although the frequent pulse continued, with much coating of the tongue and some headache, but without any febrile symptoms whatever. On the tenth day, however, while still kept in bed, she was seized with pain in the left iliac region, which on the following day became violent and did not yield to the small quantity of opium (a remedy which she could not take without very disagreeable symptoms) which I induced her to take. This pain was not accompanied by fever, and I had no doubt was malarial in its origin. Acting upon this belief she was placed upon full doses of quinine, when not only did the pain speedily disappear, but with it the frequent pulse, the headache and the nausea. The patient had come to live in the house in which she was confined but a few months before confinement, and the first evidences of the presence of the malarial poisoning in her system were those which appeared during her labor and subsequent lying-in. The dryness of the tongue and much of the nausea appearing during labor, were probably due to the opium I had given her.

Dr. Parvin remarked that the subject of Dr. Richardson's paper was one of great practical importance, and his presentation of it had been very interesting. Coming to its ultimate analysis, a case of labor, tedious in either the first or in the second stage, shows a want of proper relation between power and resistance; the former for an unusually long time is unable to overcome the latter. Manifestly if this be so, we have naturally suggested to us two plans of treatment: either increase the power or lessen the resistance. These principles are plain, but the selection and the application often present serious difficulties. Severe suffering in the first stage of labor certainly should be relieved, for this suffering exhausts, and it does not follow that the power of a pain is to be measured by the intensity of suffering it produces, and therefore "painful" pains are an undoubted evil. As to the means for their relief when they are associated, as they usually are, with very slow dilatation, many would prefer chloral injected into the rectum to morphia internally or anæsthetic inhalation. In regard to the process of dilatation of the os, it is possible Dr. Richardson has attached too much importance to the bag of waters as a dilating means; that is the mere passive

process, but there is an active process, that by which the circular fibres of the uterus are, by the action of the longitudinal fibres, retracted over the bag of waters, or the presenting part, if the former be ruptured; it is not so much the descent of the presenting part which occurs, as it is the ascent of the expanded cervix; for in primiparæ, at least, the head is usually at the beginning of labor in the pelvic cavity, and it can go no farther until the dilated os has passed more or less completely above it. It may be that resistance being lessened by chloral, or by opium, the power is sufficient to overcome it; but if it be not, probably the continuous current of electricity will be the most efficient means to increase the uterine force. In this connection, I may refer to the statements of Boyer, in his recent elaborate monograph entitled *Morphologie der Gebärmutter*. In many cases of labor where delay occurs in the first stage, it is not the os uteri that is at fault; the obstacle is higher up, and according to Bayer, the anatomical condition of this "*Stricturirung*" is the deficient unfolding of the cervix. In such condition there may be a spastic ring-like stricture or a spastic partial stricture. The first form is especially liable to occur in a narrow pelvis. Bayer recommends warm fomentations, warm vaginal irrigations, a whole bath, eventually narcotics, especially opium by rectal injection; but he strongly insists upon the continuous current as the true natural method of treatment, on the one hand relieving cramp and on the other exciting labor-activity, thus removing the primary failure, the deficient unfolding of the cervix. One word as to the occurrence of malarial poisoning in the puerperal woman. I think it comparatively very rare. Certainly this is the conclusion which I must draw from my own experience in private and in hospital practice. In two terms of service at the Philadelphia Hospital, I have seen probably forty cases of puerperal septicæmia, and only one case of malarial fever. When one sees a febrile attack in a woman after labor, he is disposed to take the most favorable view of the case, and may attribute, at first at least, the disease to malaria when really it is caused by septicæmia, losing precious time, and may be led to give a favorable when a doubtful prognosis should be indicated.

Professor Jaggard, of Chicago, upon invitation from the chair, remarked that morphia hypodermically had been extensively tried in the first stage of labor at Vienna and Paris, and had been discarded, in the former city about six years ago, and in the

latter more recently. It had been found to affect the fœtus unfavorably. One-fourth of a grain administered every four hours for some time would be attended with grave elements of prognosis. The possibility of a live fœtus remaining in the uterus forty-five days after the escape of the amniotic fluid, he considered more than doubtful. Cysts sometimes form between the amnion and chorion, and the bursting of one of these may give rise to the idea of the escape of the amniotic fluid. *Hydrorrhea gravidarum*, a condition dependent on a diseased condition of the decidua, is a more frequent phenomenon, and will explain many of the cases of supposed rupture of the amniotic sac.

Dr. W. T. Taylor remarked that the causes of delay in the first stage of labor were numerous. For the relaxation of rigid os, he would prefer hydrate of chloral twenty grains. One-eighth of a grain of sulphate of morphia, every two hours has a soothing and beneficial effect, giving rest and sleep between the pains. When the edge of the cervix is thin and wiry, the morphia is especially called for. He has experienced delay from dropsy of the amnion. After a delay of six or eight hours, he has ruptured the membranes, and after the escape of an enormous quantity of fluid, rapid and effectual contractions supervened. Another cause of delay is posterior positions of the occiput; if a change of position can be effected, labor will progress more rapidly. He has observed premature escape of the liquor amnii from ten days to two weeks before labor, and yet everything went on normally. He has met with malarial poisoning in one case. In the eighth month intense pains were experienced, but there was no effect on the os. He gave five grains of quinine and ten grains of potassium bromide, and in a few hours the pain was relieved.

Dr. Longaker stated that according to his experience morphia should be used guardedly. In some cases it has caused still-births. In a recent case the first stage of labor had lasted twenty-four hours, and the os was but one inch in diameter; four doses of sulphate of morphine, one-fourth of a grain each, were, by mistake of the nurse, given at intervals of fifteen minutes; dilatation and descent of the child quickly followed. As Dr. Parvin has stated, the early stage of labor consists mainly of retraction of the cervix, and early rupture of the membranes as a trouble is overrated. Undeveloped pelves of generally small diameters cause less delay in first labors than in later ones, because in the earlier labors the abdominal muscles are strong to

assist the uterine contractions; in later labors, besides having less contractile powers, their laxity allows the body of the child to fall

forward, and the vertex presents less favorably at the superior strait.

(To be continued.)

## EDITORIAL DEPARTMENT.

### PERISCOPE.

#### An Unusual Cause of Dystocia, Necessitating Embryotomy.

Dr. F. A. Seymour thus writes in the *Pacific M. and S. Jour.*, February:

Mrs. A., primipara, was seized with labor at term, on the afternoon of December 30, 1884. Her attendant, Dr. F. T. Bicknell, was summoned at 8 p. m., at which time uterine contractions of average normal vigor and duration recurred at intervals of five minutes.

Digital exploration revealed a healthy and natural condition of the soft parts. Dilatation of the external os was well advanced, and through the membranes a vertex presentation was easily discernible. At 10 p. m., spontaneous rupture of the amniotic membranes occurred. Complete dilatation followed, and the vertex engaged in the superior strait. The pains proving persistent and exhausting, several five-grain doses of chloral hydrate were given by mouth at half-hour intervals, but without effect. At 2:30 a. m., morphine sulph. gr.  $\frac{1}{4}$  was administered, and from three o'clock a. m. until six the patient slept. Soon after awaking, the pains resumed their frequency and force, but examination detected no fetal advance.

There seemed to be absolutely no obstruction; the pelvic space was ample, and the presenting head not unusually large. At 7 a. m., Dr. B. applied the forceps, making gentle traction and rotation, purposing thereby to stimulate an apparently misdirected *vis a tergo* to an expenditure of energy in the proper pelvic axis. But the attempt proved unavailing. As the morning wore away there was no change in the character of the uterine pains, nor in the foetal position. About 10 o'clock a. m. the patient's circulation showed signs of involvement, the pulse becoming rapid and compressible. Dr. Bicknell then requested counsel, and a messenger was sent for the writer. On examination, the condition proved as above described. The liquor am-

nii had evidently wholly escaped. The uterine walls were firmly contracted upon their contents, and the cervical lips retracted over the head and beyond the reach of the exploring fingers. There was no apparent reason why the case should not progress without interference; and further delay would probably have been advised, except for the persistence and increase of the circulatory disturbance. The possibility of version was excluded. Ether was administered, and I applied the forceps without any difficulty. But the fetus could not be moved. Repeated efforts proved wholly futile. On further consultation, embryotomy was determined upon. After evacuating the contents of the cranium and crushing in its walls, extraction was effected only after tedious delay and the repeated application of great force.

Singularly enough, after the slightest advance had been secured in the direction of extrusion, but little additional force was requisite to complete the delivery. The sensation imparted to the manipulating hand was similar to that of slipping suddenly past an obstacle. The fetus weighed but eight pounds, and the pelvic conjugates were normal; hence the source of resistance was enigmatical, until, on introducing my hand into the uterine cavity to effect the removal of the placenta, the cause was discovered.

On the right side of the uterus, at a line about midway between the external os and the fundus, the entire thickness of the powerful muscular wall projected inward with great firmness, constituting a shelf or semi-circular ridge. This had evidently grasped the fetus, the knees resting above it, and thus delivery had been impeded. In a careful study of this unique experience, light has been thrown upon very many cases in my note-book, of dystocia associated with premature rupture of the membranes, and for which, until now, I have found no satisfactory explanation.

"A dry labor is sure to be tedious," is a popular aphorism so frequently true, that it practically passes current with the profession as well. The tedium of these cases has hith-

erto been associated chiefly with (1) the removal of the protruding membranes as a distending agent, both for the uterine orifice and the vaginal passage; and (2) with the impossibility, except in rare instances, of the presenting part making pressure directly upon the os itself. But every practitioner of large experience may readily recall numerous instances in which, despite the premature escape of liquor amnii, cervical dilatation progressed with normal rapidity, while the pelvic soft parts, moist, flexible and roomy, awaited for hours the slow fetal descent.

#### Darwin's Doctrine of Evolution in Explanation of the Coming into Being of Some Diseases.

Dr. Aitken thus concludes a series of articles in the *Glasgow Med. Jour.*, February, 1886:

Thus Darwin's great work comes to be in accordance with the teachings of physiology and pathology in this respect, that "disease is not inevitably the fate and birthright of every born child, but that much of it is, in fact, of our own making; that it is not outside our knowledge and our power, but that much of it is within our own control; that filthy conditions and the imperfect removal of effete material without and within the body are the most powerful concurrent factors alike of constitutional ailments and of the zymotic pestilences which aforesometimes 'walked in darkness,' but which are daily being made plain by the revealing light of science."

"Slowly, but surely, evolution brings about an increasing amount of happiness; all evils being but accidental. By its essential nature the process must everywhere produce greater fitness to the conditions of existence, be they what they may. There is in all cases a progressive adaptation, and a survival of the most adapted, and the evils accompanying evolution are self-eliminated."\*

Hence there is in Darwin's doctrine of evolution throughout all nature the comforting belief that "it implies the design of a perpetual progress." But his too enthusiastic followers have attempted to carry his hypothesis farther than he did himself. They have endeavored to push the doctrine of evolution so far as to make it account even for the origin of life itself—a problem which Darwin never attempted to solve; but this much is certain, that "all evidence, up to the present, negatives the opinion that 'Life' is a mere evolution from organic matter;"

and while the origin of diseases in the beginning, like the first origin of life on the earth, as well as the continued life of each individual, is unaccounted for by science, and quite beyond its scope, the doctrine of evolution demands (as Darwin himself assumed), 'that we should look on the Almighty as creating the original elements of matter; determining their number and their properties; creating the law of gravitation, whereby, as seems probable, the worlds have been shaped; creating the various laws of chemical and physical action by which inorganic substances have been combined; creating, above all things, the law of life, that mysterious principle which plainly contains within itself such wonderful possibilities, and thus providing once, and for all time, the ultimate development of the many forms of nature by which we are surrounded.'

Surely, "we can conceive nothing grander than this one original creative act from which the infinite variety of the universe has come, and more is coming yet."

And this doctrine of evolution further teaches us, "that we are looking on a work which is not yet finished; that we are looking on a world in which the occurrence of pain, of disease, of death, and such like imperfections, are but a necessary part of this large design, the general outlines of which, thus far, we have been permitted to see, but the ultimate issue of which, with all its details, is still far beyond our perception."

#### Remarkable Toleration of a Foreign Body by the Eye.

Dr. Bruns thus writes in the *New Orleans Med. and Surg. Jour.* for February:

Joseph Messina applied for relief September 28th, 1885.

Born in Italy, he is twenty-nine years old, a resident of the State for three years, and at present a laborer in the rice fields of St. James Parish.

Patient states that a year ago he got a piece of rice husk in his left eye. For a day or so it caused him some annoyance. This passed away, and he has not thought of it until very lately. Very recently the eye has been troublesome; it is irritable and waters a little when he is exposed to the sun or wind.

There is a very slight circumcorneal injection, more marked around the lower portion of the cornea. Upon the latter, downwards and outwards near the inferior limbus, a small, round, yellowish brown spot about one-eighth of an inch in diameter is seen. Close inspection convinces Dr. Bruns that this is the offending bit of rice husk.

\*Herbert Spencer, *Principles of Biology*, vol. I., p. 354.



The eye being thoroughly cocanized, the husk is found to be very closely applied to the surface of the cornea, and covered with quite a thick layer of somewhat inspissated secretion (mucus), but is removed without pain or difficulty, and the patient sent on his way rejoicing.

The great degree of toleration manifested by the cornea towards the foreign body in this case, was due to the smoothness and thinness of the latter, allowing it to be closely and evenly applied to the corneal surface.

It is said that in the great grain-growing regions of the West, bits of husk often get into the laborers' eyes and set up severe conjunctival inflammations, which often resist regular treatment with approved collyria.

The quacks of the country, with that superior keenness which is unhappily so often the associate of knavery, have penetrated to the cause of these cases, and often bring relief where the regular practitioner has failed. They search the eye thoroughly, especially the upper conjunctival *cul de sac*, quietly remove the foreign body, and giving their patient a little rose-water, have him well in a day. The moral is obvious.

#### Poisoning by Chlorate of Potassium.

Dr. Simmons B. Jones, of Charlotte, N. C., reports the following interesting case in the *Med. Record*:

A little girl, nine years of age, had been under his care for a slight fever, with weak pulse, nausea, and continual vomiting, but, having apparently recovered, was dismissed as cured. On the day following, July 26th, the child had a sore mouth, and her mother gave her a paper containing something over an ounce of chlorate of potassium, allowing her to take it *ad libitum*. The girl liked the taste, and ate the crystals all day, consuming in this way between two and three hundred grains. At about two o'clock on the morning of the 27th the patient awoke vomiting. When seen some five hours later she was deathly pale, with blue lips, and a very rapid and feeble pulse, and presented exactly the appearance of one who had had a sudden and copious hemorrhage. "I had no idea at this time of the cause of the trouble, the parents having said nothing about the chlorate of potassium, believing it to be a harmless drug; but I suspected poisoning. The patient remained in this condition the three following days, vomiting and being unable to retain any food, and passing no urine. On the fourth day I introduced a catheter and drew off about five ounces of

smoky urine, which, on examination, was found to contain albumen, casts, and altered blood. Dr. H. Formad, of the University of Pennsylvania, who examined a specimen, reported: 'I fully coincide with you about the urine; it contains a very large quantity of granular blood, epithelial casts, and free blood, showing a profound renal affection.' The urine was drawn for several days, and then began to be passed naturally in sufficient quantity, the blood disappeared, and the water resumed its normal color. An analysis, by Dr. Hannah, of eight ounces drawn the second day, showed six grains of potassium chlorate. The vomiting continued until August 14th, the matter vomited consisting of dark green mucus of an offensive odor. On August 16th there was seen an eruption of small maculæ of a purple color, upon the forearm. The temperature rose to 100° on the 20th, the submaxillary glands became swollen, the throat was red and œdematous; the patient sank gradually, and died on August 26th. She never complained of much pain, and there was no tenderness over the stomach. The bowels were at first constipated, but when action was solicited the matter passed was dark, and resembled the urine in appearance. There was complete anorexia throughout the entire period. Life was sustained by enemata of beef peptonoids, and milk, until the rectum became too irritable to retain the injections. After the vomiting had ceased, the patient was able to retain a little buttermilk. During the first few days much relief was obtained by warm baths, which were always followed by profuse perspiration and quiet sleep." No autopsy could be obtained.

#### Habitual Abortion and Kidney Disease.

The *Brit. Med. Jour.* says much has recently been written on albuminuria in pregnancy, and on the relation of disease of the kidney to physiological and morbid enlargement of the uterus. At the recent meeting of German scientists and medical men at Strassburg, Dr. Fehling, of Stuttgart, read a memoir on habitual death of the embryo in kidney disease. In the first case under his observation, premature expulsion of a dead foetus occurred six times, and there was no evidence of syphilis. At every pregnancy, anasarca, albuminuria, and death of the foetus, with severe cramp of the abdominal muscles, occurred between the fifth and sixth month; the dead foetus was expelled from three to ten weeks later. In the second case, similar symptoms appeared in a young

inipara; the fœtus died, and thereupon the albuminuria abated. In the third case, the patient had borne two healthy children. During the third pregnancy, albuminuria and characteristic changes in the retina occurred; and during the fourth she was seized with hemiplegia; in both, a decomposed fœtus was expelled at the fifth month, with subsequent decrease of the albuminuria. In the fourth case, the patient, in her first pregnancy, aborted at the fifth month; then she gave birth at term to a recently dead child. In the third pregnancy, great cedema and albuminuria supervened, the child was still-born, and the mother died of uræmia. Dr. Fehling believed that, in all these cases, kidney disease existed before pregnancy, which aggravated the renal symptoms. Winter had described two cases of premature detachment of the placenta, normally situated, where albuminuria existed. Dr. Fehling found atrophy of the villi of the chorion, with wedge-shaped or spherical infarcts in the placenta, in his cases, similar to renal infarcts. The infiltration of the chorionic villi and vessels of the umbilical cord with small cells, as seen in syphilis, was absent, nor did any of the embryos exhibit a trace of congenital syphilis.

#### The Control of Hemorrhage.

Dr. A. Maguire thus writes in the *New Orleans M. and S. Jour.* for February:

In ante-bellum days, I was called to a large plantation in my neighborhood by the manager, one of the old-time overseers, who had great confidence in his powers of healing, and was convinced of his superiority over any new-fledged Æsculapius, and that what he did not know of medicine was not worth knowing.

He pointed to a collapsed, ghastly-looking African, sitting on a verandah, with his head leaning against the brick pillar, blanched as much as his color allowed, and with a small stream of blood and saliva trickling from one corner of his mouth; he had extracted, twenty-four hours before, the third molar, and the blood had never stopped—he had applied strong vinegar, Pravaz's perchloride of iron, nitrate of silver, and had caused the blacksmith of the plantation to bend and file down to a point a goodly-sized wire with which he had cauterized the socket. After doing all this he confessed he was at his wit's end, "*au bout de son latin.*" I told him I would extend his Latin to "*Felix qui potuit rerum cognoscere causas,*" and after reviving the drooping African with a square dose of

whisky, I made a wad of cotton to be compressed between his jaws, leaving a piece protruding in the mouth of sufficient size to allow the involuntary play and suction of the tongue to be exerted on it, and not disturb the formation of the clot in the socket. The hemorrhage was arrested in ten minutes.

Some time afterward, a planter living some ten miles from my house sent for me for his daughter, who had been bleeding some twelve hours from same cause. I directed the father to apply same wad, and gave two doses of brandy and digitalis, which set everything right.

On the same principle, violent epistaxis can be controlled in many instances by occluding the nostrils between thumb and finger, preventing the forced entrance in and out of air, also an involuntary act, during which no clot can be formed.

## REVIEWS AND BOOK NOTICES.

### NOTES ON CURRENT MEDICAL LITERATURE.

—Godey's *Lady's Book* for March presents some notable attractions, not the least of which is a cleverly executed frontispiece portraying "The Frown," a companion picture to "The Smile," which proved to be such a point of merit in the January issue.

—A catalogue and price-list of artificial anatomical models can be had by addressing Dr. Lemer cier, No. 7 Rue Vavin, Paris.

—At the last meeting of the Philadelphia Social Science Association Dr. Benjamin Lee read a paper on the organization of local boards of health in Pennsylvania, copies of which can be had by addressing the Social Science Association, 720 Locust street, Philadelphia.

—In a reprint before us, Dr. P. T. Armstrong, of the Marine Hospital Service, describes an interesting case of necrosis of the frontal bone following inflammation of the frontal sinus.

### BOOK NOTICES.

*Leçons sur l'Étiologie et la Prophylaxie de la Fièvre Jaune.* Par le Dr. Manuel Cremona y Valle. 8vo., pp. 299. Illustrated. Mexico, 1885.

The scourge of tropical America is the yellow fever, and that its destructive ravages

are not limited to the tropics has been fearfully illustrated by the medical history of our own country. Any discovery which would offer a reasonably sure and easy method of prophylaxis against it would be one of the greatest boons to humanity, and would open up to the access of immigrants vast tracts of fertile land now effectually closed to them.

There seems good reason to believe that this discovery has been made by Dr. Carmona y Valle, the author of the work before us. It is by the method of inoculation of the specific virus of the disease into healthy subjects. Very strong testimony to the same effect has also been laid before the scientific world by Dr. Freire, of Brazil, who indeed claims to be the author of the method. Into the question of priority we shall not enter, and it is quite possible that like many discoveries it was originated independently by more than one observer.

Dr. Carmona's volume is published in French by the Mexican Ministry of Public Works, with an introduction and notes by Dr. E. Liceaga. It is illustrated by photographs and chromo-lithographs representing the specific microbe to which the disease is attributed. The explanation of the symptoms is ingenious, and the origin of the disease in various localities is carefully studied. The method of inoculation is described, and its protective effects demonstrated by the record of numerous instances of exposure without contracting the disease. Altogether the book is one of the first order of importance in prophylactic science.

**On the Supra-pubic Operation of Opening the Bladder for the Stone and for Tumors.** By Sir Henry Thompson, F. R. C. S. Pp. 57. London: J. & A. Churchill, 1886.

This interesting monograph contains a history of the operation, a record of a number of cases, and a discussion of its merits as compared with others for the same purpose. It is well illustrated, and written with the usual ability of the author.

**Practical Human Anatomy.** By Panueil I. Weisse, M. D., etc. Illustrated by 222 lettered plates, containing 321 figures. 8vo., pp. 456. William Wood & Co., New York. 1886.

This treatise is intended both to be a working guide or dissector for the use of students, and also a reference book on anatomy for practitioners. The illustrations are on stone and are generally satisfactory, though here and there the lettering is less clear than one might desire. Their great merit is that they

are nearly all directly from nature by the hands of a most competent artist, and not borrowed from previous treatises.

The text is concise and clear, and confines itself strictly to the anatomy of the part, not embracing its surgical aspects. To many this will doubtless be a disappointment, but we agree with the author in his opinion that anatomy is a science by itself, and should at first, at all events, be studied as such. After the description of each organ or part, the rules for its proper dissection are given in print of a smaller size. As the author has had experience in teaching anatomy in one of the largest medical colleges in New York for many years, he has acquired a thorough knowledge of how best to present his topics so as to insure their facile comprehension. The work is provided with extensive indices, and is manufactured in a highly satisfactory manner.

**The Temperance Teachings of Science.** By A. B. Palmer, M. D., LL. D., etc. Pp. 168. Boston: D. C. Heath & Co., 1886.

This is one of the books "adapted to the use of teachers and pupils in the public schools" which have been brought into existence by the educational tactics of the total abstinence crusaders, to which we referred in a recent issue. It comes from the pen of a member of our profession justly distinguished for his learning, and not less for the aggressiveness with which he defends his views.

In his book, as in others of the kind, the real point is dodged. Dr. Palmer labors to prove what no one denies—the evils of intemperance—and then by these pretends to have shown that temperance—the moderate use of fermented beverages—is also hurtful. A more complete ignorance or disregard of logical method could not be adduced. It is equalled by the physiological absurdity which prevails throughout the work, of maintaining that the effects of fermented are the same as those of distilled liquors. It is paralleled by the author's complete misapprehension of the evils of total abstinence, shown in his remarks on page 162. He fails to grasp this, which is one of the most important points in the whole subject. No nation and no party will ultimately succeed which departs from the doctrine of Him who came "eating flesh and drinking wine," who was Himself straightly charged with being "a wine-bibber and a glutton," but who in all matters of food and drink taught "temperance in all things, abstinence from nothing." To this all sound physiology points, and all education and government should point.

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### THE MANUFACTURE OF ACETATE OF LEAD AND ITS INJURIOUS INFLUENCES UPON THE WORKINGMEN CONNECTED WITH IT.

For years science has endeavored to prevent lead-poisoning in those whose occupation brings them into intimate and continuous contact with the metal.

Not only in the foundry-department, but still more in those, where the product is powdered, collected and packed ready for shipment, poisoning by lead is possible. Dr. F. Boehm has made many observations in this respect, and from his article in the *Deutsche Med. Zeit.*, Jan. 11, 1886, we make the following extracts:

It is of importance to know, that the first symptoms of intoxication consist in disturbances of digestion, and if the laborer does not then consult a physician, signs of lead colic develop, soon followed by vomiting, cold perspiration and intense colicky pains, with violent constipation. Under correct treatment, improvement sets in within a few days. Should the laborer return to the factory after repeated attacks of lead colic, chronic poisoning occurs; lead tremor, paralysis of the extensor muscles, epileptiform convulsions and affections of the joints belonging to its symptoms. In some cases peculiar physical disturbances occur; the patient is seized with mania, or becomes an idiot. These signs of mental aberration generally last some weeks, and then cease, only to return after intervals varying from one to several months, if the patient, notwithstanding his physician's advice to the contrary, should again resume his former occupation. Females are far more predisposed to lead-poisoning than men; this is the reason why in the great lead factory in Gademann in Germany female help is no longer engaged. It has been demonstrated that men in the habit of chewing tobacco generally escape lead-poisoning or are far less predisposed to it, but science has not yet divined whether this fact is due to any special action of the nicotin, or whether in consequence of the greatly increased salivary secretion in chewers, the small particles of lead are expectorated or made more or less innocuous by the alkalinity of the saliva. If at the very commencement, when only disturbances of digestion and an inclination to constipation exist, laxatives are promptly administered, the outbreak of the lead colic may be prevented. But should any pain exist, laxatives are not only without effect, but directly injurious. Warm cataplasms, opium internally or morphia subcutaneously and only after cessation of all pains the administra-



tion of drastic purgatives, form then the correct treatment.

As prophylactic measures, the following are in vogue in the large factory mentioned, which, by the way, is looked upon as the model institution of its kind. Laborers receive special *overalls*, which they wear while at work, and peculiar gloves, so arranged as tightly to surround the wrist without interfering in its motion, thus preventing all absorption by the skin, as the overall and gloves are of a material which is impermeable for the finest dust. Immediately before meals—which are permitted to be taken only in certain rooms and at definite hours—and also after their day's work is done, the overalls and gloves are carefully removed; face, hands, and hair are thoroughly washed; the teeth are cleansed with special brushes, and pure water is inhaled through the nostrils; in the rooms where the lead is worked as powder every laborer is forced to wear a respirator—incorrect wearing of which, if detected, at once causing the discharge of the man—and at least twice daily every laborer must take a tepid bath.

Experience, however, has proved that the men are too indifferent to prevent the occurrence of lead-poisoning. While those who strictly follow the rules, as mentioned, and who use all the year round, instead of plain water, a lemonade made with diluted sulphuric acid, may work for years and years in such factories with perfect impunity, others become poisoned by lead because they neglect the necessary precautions. Only technical chemistry, by the invention of less injurious coloring material, can cause the disappearance of the frequently dreadful disease.

#### LIVING IN NEWLY BUILT HOUSES.

In Prussia exists a law forbidding the renting of newly built houses for a stated period after their completion. This period somewhat varies according to the amount of humidity in the soil of the district. Recently a commission was appointed to investigate the subject, and to determine whether any change in the law would be desirable, the law having been in existence for over thirty years.

This commission has recommended the abolition of the law, and the substitution instead of more stringent building regulations. They say that the government should insist in any new building upon all measures necessary to prevent entrance of water into any part of the house. In regions where the

ground water often rises high, a layer of cement should hermetically surround the cellar and ascend to a certain height above ground. Other precautions are recommended for the purpose of insuring water-proof roofs. But the main point in the commission's report is the question of ventilation. They advise the government to appoint a commission to determine the most feasible plan for insuring perfect ventilation in all dwellings and, then to pass laws enforcing such ventilation in all newly built houses.

In conclusion they express the positive conviction, if their recommendations are carried out, and if the respective building authorities see that no defect in ventilation, or in the other measures, can creep in, that newly built houses can at once be tenanted as soon as they are completed, without the least injury to the health of their occupants.

There is no doubt that a similar stringent law and its stringent enforcement by competent building commissions are just the things needed in our country. But if we remember that, in a city like New York, a tenement house before its completion can cave in, simply in consequence of a little breeze, as happened about a year ago, when only the accidental fact of a person being killed by the collapsing walls insured the punishment of the builder (but not of the commissioners!) it surely is time to enact some such laws this side of the Atlantic, and to take as commissioners men that not only understand their business, but are determined to carry out the provisions of the law.

#### SULPHUR IN GAS.

The question has recently been agitated, whether our illuminating gas contains any considerable amount of sulphur, the idea having gained ground that this substance, if present, would be injurious to the health of persons inhaling air saturated with it. The well-known authority on sanitary matters, Von Pettenkofer, has made this subject a special study, and after a long series of experiments he has come to the following conclusions, published in the *Deutsche Med. Zeit.*, January 11, 1886:

He is of the positive opinion that it is of no importance whatever, from a sanitary point of view, as well as from a chemical-technical one, whether an illuminating gas, provided it be free from sulphuretted hydrogen, contain 0.2, or 0.5, or 0.7 (about  $\frac{1}{10}$  grains) sulphur per cubic meter, or none. Those using the gas have not to expect any advantage whatever from the present chase after sul-

phur in gas; it can be of interest to them only that the gas is free from sulphuretted hydrogen, and that it possesses sufficient illuminating power.

Thus one other of the recent scares has been removed from anxious brains. There is no doubt that many of our modern achievements, as for instance gas, aqueducts, sewerage, etc., are by no means conducive to health; but in the chase after injurious influences, and after factors deleterious to health, many a wrong position has been maintained, and this will probably continue until science has finally sifted the material accumulated, and determined what is hurtful and what not.

## NOTES AND COMMENTS.

### The Surgical Treatment of Cysts of the Pancreas.

Of all abdominal organs the pancreas has been least frequently subjected to surgical treatment, for which the anatomical location of this organ, and the obscurity of its affections, furnish a sufficiently satisfactory explanation. Situated high up in the abdominal cavity, and hidden behind such important organs as the stomach, omentum, and transverse colon, it is the least accessible of all abdominal organs, and on this account its affections, wrapped in obscurity, have for the most part constituted objects for empirical medication. The relation of this gland to the surrounding organs and its great distance from the anterior wall of the abdomen, the only point of approach, necessarily offer serious obstacles to diagnosis and direct treatment. From a diagnostic point of view another great difficulty is our want of positive knowledge concerning the physiological functions performed by this gland in the process of digestion. As the symptomatology of all affections of the pancreas is always obscure, and a probable diagnosis can only be made in cases where the gland has become considerably enlarged by disease, it is apparent that our present clinical knowledge is limited to diseases which increase the size of the organ to a sufficient extent to permit its detection by palpation. Primary malignant disease of the pancreas, when it has advanced to such an extent that its presence can be diagnosed with certainty by physical signs, will have invaded the adjacent tissues to such a degree as to preclude the advisability of an operation; consequently the efforts by the surgeon, for the present at least, must be directed exclusively toward

the recognition and treatment of benign affections of this gland. Clinical experience does not extend beyond an imperfect knowledge of cysts of the pancreas.

The pancreas, like other secretory organs, is prone to become the seat of cystic tumors, the result of obliteration or obstruction of the common duct, or one or more of its branches. Cysts originating in this manner are true retention cysts, containing the physiological secretion from the distal portion of the gland tissue, with perhaps accidental products, such as altered secretions, blood, and the products of inflammation.

In a very valuable paper on the surgical treatment of cysts of the pancreas, Dr. N. Senn, of Milwaukee, in the July number of *The American Journal of the Medical Sciences*, presents a full report of a case of retention cyst of the pancreas, which has recently come under his observation, and, at the same time, summarizes, in a compact form, the clinical history of similar recorded cases which serve as a basis for some general remarks.

In recapitulation, Dr. Senn submits the following conclusions:

1. Cysts of the pancreas are true retention cysts.
2. Cicatricial contraction or obliteration of the common duct or its branches, and impacted calculi, are the most frequent causes of cysts of the pancreas.
3. A positive diagnosis of a cyst of the pancreas is impossible; a probable diagnosis between it and some other kind of cysts amenable to the same surgical treatment is adequate for all practical purposes.
4. The formation of a pancreatic fistula under antiseptic precautions recommends itself as the safest and most expedient operation in the treatment of cysts of the pancreas.

### The Influence of Cocaine, Atropine, and Caffeine on the Heart and Blood-Vessels.

There are few known drugs that have, within such a short space of time, risen from comparative obscurity to such practical as well as theoretical importance as cocaine. Its great value as a local anæsthetic, and its wide application in all the branches of medicine and surgery, together with our comparative ignorance in regard to many points of its action on the animal organism, are sufficient to attract attention to a valuable experimental paper on the influence of cocaine, atropine, and caffeine on the heart and blood-vessels, by Dr. H. G. Beyer, U. S. N., which

appears in the July number of *The American Journal of the Medical Sciences*.

Dr. Beyer finds—

1. That *cocaine* is exceedingly prompt and uniform in its effects upon the heart.

2. In small doses it is a powerful stimulant to the heart's action.

3. In medium doses it has an inhibitory influence over the ventricular contractions.

4. In large doses it produces diastolic arrest, from which, however, the heart may be recovered under suitable conditions.

5. In small or large doses it produces contraction of the blood-vessels, independent of the central nervous system.

6. A rise in the blood pressure, consequent upon the administration of cocaine, is due to a direct action of the drug on the heart and blood-vessels, stimulating the former and constricting the latter; a fall in blood-pressure coming on after the rise must be accounted for by the action of cocaine on the heart alone, since its constricting influence on the blood-vessels outlasts the stimulating influence it exerts over the ventricle of the heart.

2. That *atropine* in certain doses increases the rate of beat of the heart, and also the amount of work done.

2. That it exercises an inhibitory influence over the contractions of the ventricle.

3. That it first causes a contraction and afterwards a dilatation of the blood-vessels.

4. That cocaine acts on atropized vessels in the same way that it does on normal ones, *e. g.*, it causes their contraction.

That *caffeine* in small as well as large doses produces dilatation of the blood-vessels in the terrapin; any rise in arterial pressure due to caffeine is, consequently, to be explained only by the stimulating effect caffeine exerts on the heart itself.

the letters in the word. The patient observed that this annoying symptom was most frequent when the flashes of light were most troublesome. Another noteworthy fact in connection with his visual organs was the long persistence of negative images, a condition which was not always present, but only at the times when he felt bilious. There had never been convulsions or motor spasms of any kind; nor with the exception above mentioned has he ever lost consciousness. At times the patient was troubled with a ringing noise apparently in his right ear; he was, however, distinctly though not very deaf on the right side. Reflecting on this symptom of apparent lengthening of a word, it occurred to Dr. Angel Money to ask his patient whether he ever experienced a similar alteration in the length of spoken words. There was no weakness of any ocular muscle, and only a trifling degree of myopia. The author remarked that there were many ways of interpreting this symptom. He did not think there was any fraud or reasonable doubt that the symptom was a real one. Was it due to some transient disturbance in the muscular mechanism of the eyes? The author thought this supposition not at all improbable. But he considered that theoretically it must not be overlooked that we may have to do with a symptom belonging to what may turn out to be an altogether new field of sensory nervous symptoms, by which he meant a group of symptoms which might best be designated as "reduplicated nervous actions." If the patient be right in his opinion that one of the letters of a word is doubled in the apparent lengthening, then it would not be at all absurd to regard the phenomenon as due to the reduplication of a nervous discharge in the usual word centre.

### A New Symptom in Megrin and Epilepsy.

Before the Clinical Society of London (January 22), Dr. Angel Money read a paper with this title. The patient in whom the new symptom was noted was a man, *set.* 29. He had suffered from many of the symptoms that are usually put down under the heading of megrim, such as transient hemiopia, spots and flashes of light, headache with and without nausea, abnormal tactile sensations. When about eleven years old he used to faint with a queer sensation at his epigastrium. The new symptom consisted in an apparent momentary lengthening of a written or printed word, seemingly caused by a reduplication of one or more of

### Chronic Simple Ulcers of Stomach and Duodenum without Symptoms until the Occurrence of Perforation.

The following case, which Dr. Samuel West reports in the *Med. Press*, January 27th, is well worthy of remembrance, as it serves to help us out of "scrapes."

Hannah A., 48, while eating, was seized with sudden severe pain in the epigastrium, which continued until her admission a month later. She had vomited, but food produced neither pain nor sickness. She had rapidly lost flesh and strength, and had recently perspired at night, and for a few days had a cough which caused her pain in the right side and back. She had been all the

time confined to bed, and a bed-sore formed upon the right buttock a fortnight before admission. Though she had been losing strength lately, there was no history of any ailment before the present illness. There had never been any pain or discomfort after food. Patient looked very ill. Respiration 46, shallow, general rhonchus. P. 120, very fresh. T. 99°. Urine a trace of albumen. Liver uniformly enlarged. Some tenderness above umbilicus and towards right hypochondrium. No ascites, but œdema of legs. Two days after admission she passed with a stool about six ounces of dark blood, and also on the two following days. She rapidly became weaker, and died on the 5th day after admission. P. M.—Some old chronic pleurisy and pericarditis. Liver enlarged, with superficial abscess between it and abdominal walls. This abscess had two openings—one leading from duodenum and due to perforation of an old ulcer, the second into the colon, probably accounting for the hæmorrhage. Another large chronic ulcer was found upon the lesser curvature of the stomach, which had also perforated, and led into a cavity with thick fibroid walls, and the base of which was formed by the liver. The two ulcers were of very old date, the symptoms being produced by the perforation of the duodenal ulcer, and the formation of the abscess. Two points are noteworthy:—1. The extent and duration of the ulcers without symptoms. 2. The lowness of the temperature in spite of active suppuration.

#### Weighted Shoes in Locomotor Ataxia.

Dr. Allan McLane Hamilton thus writes in the *Boston M. and S. Jour.*, January 21:

Those of us who are in the habit of seeing locomotor ataxia, especially in its second and third stages, have our sympathies taxed to their utmost by the helplessness of the tabetic patient and his difficulty of getting about. There is very little to be done at best, and for this reason the case seems sadder than ever.

For such ataxics I have been in the habit during the past four or five years, of suggesting a simple mechanical device which has done so much good that I think it worthy of publication. I allude to weighting the anterior part of the feet. Many ataxics whose locomotion was exceedingly difficult and distressing, have worn their weighted shoes constantly since I ordered them, and have led far happier and more comfortable lives.

Those at all familiar with the peculiar heel gait of the ataxic, know that there is

more or less weakness of the peroneus longus, and a failure to act against its opponent, the tibialis anticus, which is strongly contracted. Buzzard and Jackson first called attention to this explanation of the disorderly walk which largely depends upon what the former calls the "over-movement of the associated muscles." The use of the properly adjusted toe-weights serves two purposes—*first*, to overcome the tendency to violent hyperflexion; *secondly*, to create an exaggeration of subjective consciousness of movement and location. The loss of plantar tactile sensibility is compensated by the perception of weight. In some cases with the adjusted weight it is possible for the patient to walk in the dark, which under other circumstances he could not do.

The weight, which should not be so great as to produce fatigue, may consist of a leaden insole, or of a plate fastened between the soles. A few experimental trials will enable the physician to determine just how much lead is needed, and where it should be placed. For those cases which last some time, the degree of comfort is sometimes very great, and the patient's gait is less apt to attract the attention it would otherwise, thus saving him much mortification and giving him greater confidence.

#### The Prevention of Myopia in School Children.

It is now tolerably well established that shortsightedness is developed and increased in a certain direct relation to the amount of school-work done by children. For the prevention of myopia, Fuchs, of Liège, in a prize essay quoted in the *Birmingham Medical Review*, gives the following directions. First in importance is the arrangement and lighting of the school-room.

"The principal windows in England should look to the south or south-east. The long axis of the room should run north and south. Every scholar should, from his place, be able to see some portion of the sky. Light from above is the best, and, except in hot climates, glass roofs are very advantageous. The chief light must come from the scholar's left side. The height of the top of the window from the floor should not be less than two-thirds the width of the room. The total window surface should bear to the area of the floor a proportion of at least 1 to 5. In artificial lighting by gas, every burner must have a glass chimney and a shade, the latter arranged to reflect the light down upon the desk, and to screen the scholar's eyes. There



should be about one burner to every four scholars."

#### Azoturia.

The *Lancet* (January 2) says that an estimation of urea discharged in a given time has been long regarded as a scientific means of diagnosis, not only in renal disease, but in other disorders which disturb the normal exchange of material. Within the last two or three years M. Rommelaere has made certain statements which, if true, would certainly afford additional help in the differential diagnosis of gastric diseases. Azoturia is a convenient term to signify the normal discharge of nitrogen in urine. It used to mean hyperazoturia, and we now also speak of hypoazoturia. But difficulties still exist in the way of nomenclature, for no one knows the normal discharge of nitrogen. It is asserted in text-books of physiology that 500 grains of urea are the normal amount discharged by the average healthy man in the twenty-four hours. But this seems to be an arbitrary standard. The objections that have been raised against Rommelaere's conclusions (*vide The Lancet*, p. 604, vol. ii., 1884) are four in number: 1. The estimate of thirty-two grammes for the normal azoturia is too large; in France it is given as twenty-one grammes. 2. Azoturia is proportional to the kind of diet. 3. A patient who is not fed, or who vomits his food, has hypo-azoturia, no matter what his disease. 4. Cancers may be associated with hypo-azoturia. Rommelaere admits the force of the first two objections, though he thinks his own conclusions are not perceptibly altered thereby. Theoretically there are objections, but not practically. He adduces evidence to show that the degree of azoturia is not in direct relation with the quality and quantity of the food in acute diseases, nor even in chronic affections.

#### The Treatment of Lithæmia.

If asked how he would manage a case of lithæmia, Mr. Charles G. Stockton tells us in the *Buffalo Med. and Surg. Jour.* for February that he would answer: avoid quinine; look carefully after gastro-intestinal catarrh; keep open all the sewers of the body, including the liver; be most mindful of the primary digestion, and suit the diet to the case; using, if needed, pepsin and hydrochloric acid with albuminoids, vegetable diastase with starches, and extract of pancreas with milk and the fats, after the admirable plan of Roberts, of Manchester. And finally, the most important and most neglected agent of all, oxygen,

should be gotten into the body. Do this by massage, which will improve the capillary circulation and hasten the lymph stream; by inhalation of oxygen, which promises much in this direction; by change of climate, or, if the case is not urgent, enjoin as far as practicable, an active out-of-door life, with horse-back riding; for if there is anything that is truly anti-lithæmic, exercising, exhilarating, tingling a man into the belief that he is related to the gods, that thing is equitation.

#### Pregnancy Mistaken for Cysto-sarcoma.

From Tassy, in Roumania, the following case is reported:

A peasant woman, twenty-five years old, who had had already seven children, and who had had no sexual connection with her husband for more than four years, felt herself pregnant several months after an illegitimate coition. To hide her pregnancy from her husband, she simulated violent pains in her abdomen, the cause of which was a tumor enlarging her belly, and went to Tassy, into the Saint Spiridion Hospital (not into the lying-in hospital). Here was diagnosed a cysto-sarcoma of the right ligamentum latum, and laparotomy with consequent incision of the presumed cyst was performed. Instead of a cysto-sarcoma, they found a child of seven months, which remained living for some hours. The mother died on the seventh day. The respective physicians have been drawn to account, and the operator removed from his office.

#### Feeding by the Rectum.

The following formulæ for this purpose are given in *The Practitioner*, Dec., 1885:

For peptonized gruel: wheaten flour, oatmeal, arrowroot, sago, pearl barley, pea or lentil flour, gruel well boiled, thick and strong, Oj; put in a covered jug, cool to about 140° F., add liq. pancreatici ʒss. Keep warm under a cosy for two hours, boil and strain.

For peptonized milk gruel: thick hot gruel, cold milk, equal parts. To each pint add liq. pancreatici ʒij-ij., and sodii bicarb. grs. xx. Keep warm in covered jug for two hours; boil for a few minutes and strain.

For peptonized beef tea: half pound finely minced lean beef, water a pint, sodii bicarb. grs. xx.; simmer for one hour and half; cool to 140° F.; add liq. pancreatici ʒss. Keep warm under cosy for two hours; occasionally shake. Decant liquid portion and boil for five minutes.

### When Not to Operate in Empyema.

This is a question that it is not always easy to decide, but that there are some cases wherein an operation is contra-indicated we all know. Thus Dr. Rickman J. Godlee tells us in the *Lancet*, January 16th, that in chronic phthisis an empyema may be present and apparently do no harm for a considerable period, but its evacuation may be followed, apparently as a result, by increased destructive changes in the lung; it may certainly, if the greatest care be not taken, be followed by increased constitutional disturbance from inflammation of the pleural surfaces. These cases should then, he thinks, be let alone as long as the presence of the fluid is not a source of inconvenience to the patient.

### The Early Treatment of Convergent Strabismus.

Dr. W. Adams Frost concludes a paper in the *Brit. Med. Jour.*, January 16, 1886, by enunciating the following propositions:

1. The cure of a squint is important, not merely for cosmetic reasons, but because it is essential for binocular vision, and because, if neglected, the sight of the squinting eye will be very seriously impaired.
2. Treatment must on no account be postponed when the squint has ceased to be alternating.
3. The majority of cases, if seen sufficiently early, can be cured by correcting the hypermetropia.

### Post-mortem Hyperpyrexia.

A singular case of this kind is reported by Dr. E. Underhill in the *Lancet*, January 16, 1886. The patient was a woman aged thirty-five, who, after labor, presented some evidences of a commencing mammary abscess. There was no evidence of organic disease, but she complained of feeling very hot, though she suffered no pain. She died, although but a few hours before, a favorable prognosis had been made. A few minutes after death the thermometer in the axilla registered 110.2° F., and two hours later, after the chest had been exposed to the atmosphere, it was 108° F.

### Lanolin.

This new base for ointments is described and highly lauded by Dr. Oscar Leibrich in the *Brit. Med. Jour.*, January 16. It has a great capacity for absorbing water, more than 100 per cent. of which can be kneaded

with it. The absorption of lanolin-sublimate ointment is so rapid that a few minutes after the application the characteristic metallic taste is observed. It is noteworthy also that this fat combines easily with glycerine, and that, in this combination, it can with ease be mixed with every other fat. In this way a great variety of agreeable cream-like ointments can be produced.

### Diagnosis of Gonorrhoea in a Female.

The *Jour. Cut. and Ven. Diseases* tells us that Dr. Martineau claims that a specific may be distinguished from a simple vaginal discharge by the simple expedient of using a piece of litmus paper. In the specific form the reaction is always acid, while in the simple form it is always alkaline. The same test is also of value in cases of rape, in deciding whether the person who committed the crime was then suffering from gonorrhoea, as the vaginal discharge proceeding from this cause would be acid.

### Salicylate of Sodium in Pericarditis.

Dr. Da Costa tells us that he is losing confidence in the power of the salicylates to prevent or cure the heart complications of rheumatism, and he gives a decided preference to the alkaline treatment; yet, on the other hand, Dr. Samuel L. Abbott states in the *Boston Medical and Surgical Journal*, January 21, 1886, that while the cases he offers are too few to generalize from, yet he cannot resist the conviction that the drug exerted a decided influence on the disease.

## CORRESPONDENCE.

### BERLIN CORRESPONDENCE.

#### A New Method of Treatment of Tuberculosis of the Lungs.

EDS. MED. AND SURG. REPORTER:

Well, then, the year would have a good beginning—with a new treatment of chronic tuberculosis of the lungs and chronic bronchitis—if only *new* and *approved* were also always identical. Max Reichert, at Rosstock has, several years ago already, healed tuberculous ulcers of the larynx with injections into the throat of a two per cent. solution of chloride of zinc. These results laid the idea before him if it would not be possible to influence the tuberculosis of the lungs through a similar local treatment. With the inhalation of medicinal vapors, the intended purpose is not obtained, because the

inhaled quantities are too small; the penetration of medicaments in the shape of powders into the lungs the author does not think very possible, but, on the contrary, he believes the process which he explains more particularly in the *Archiv. für Klinische Medizin*, vol. 37, heft 5, worth further examination.

The method consists in injecting medical liquids directly through the larynx into the trachea and the bronchi of the affected side of the lungs. Already six years ago this method had been made use of in chronic bronchitis and bronchiectasis. The remedies used for injection were lime-water, a  $\frac{1}{2}$  to  $\frac{1}{4}$  per cent. solution of chloride of zinc, ol. eucalypti (5 per cent., with water or glycerin), ol. myrrhæ, ol. pini pumilionis, thymol  $\frac{1}{4}$  per cent., ol. menth. pip., salicylic acid (up to  $\frac{1}{4}$  per cent.), salicylic acid 1.0 to 2.0 mixed with ol. menth. pip. 3 to 6.0, aq. dest. qu. suff. ad 2000. The best results have most likely been given by salicylic acid; also eucalyptus oil was of good effect.

The most important, and for the value of this method of treatment above all deciding question, was that, if and how far the liquid got into the lungs. The first made trial of the author in this respect is in that way, that as Leubuscher correctly mentions in *C. f. klin. M.*, No. 2, 1886, it is not very clear how he shall contribute anything to the decision or to the enlightening of the matter in question. In the lungs of a calf or sheep closed with cork a solution of methylic blue is injected by means of a syringe for the throat. Altogether eight injections were made. Afterwards methylic blue was found in all parts of the lungs. However, the author did not content himself with this one trial, but made use of two animals, a rabbit and a sheep, for the experimental decision of the said point. As far as the rabbit was concerned, he himself asserts that it is questionable if in general anything of the injected liquid came into the trachea; with the sheep, however, the case was different; here tracheotomy was made before, and twelve injections of crocus solution were made. It is true, the animal got dyspnoea, but the crocus solution was found after death in all parts of the lungs. The author, it is true, doubts in his demonstrations in his trial on animals (and that is no more than justified — L. C.); but, nevertheless, he thinks it undoubted that in man these injections would get into the lungs. And why? The subjective sensation of the patients gives the principal proof for it. For instance, by injections of light oil of wine,

the patient mentions a burning in the parts of the trachea; after a number of such injections a dyspnoea takes place, only perceptible to the patient, which objectively is cognoscible through a slight crackling. From the irritation caused by the injection, R. has never seen any harm. Especially with bleedings of the lungs, these injections of light oil of wines have a downright prophylactic, sooner styptic effect. The consequence of these injections is in the first place the regular emptying of the products of secretion, as well through the inclination to cough caused by the injections as also the solvent action of the water, and through the animation of the activity of secretion of the bronchial pituitous tunic. Then, further, the disinfecting and astringing, eventually the healing and cicatrizing, exciting action of the injected liquid, as far as this has got into the lungs. Finally, this liquid becomes also resorbed, and after having been taken up in the mass of moisture of the body will also be able to operate.

The observations of R. extend to 60 cases. Always a favorable result was to be observed. Already after a few days could be observed also in the more difficult cases a striking improvement of the general state of health. The expectoration became easier, cough more seldom, vomiting left off, breathing became freer, the appetite better, sleep more tranquil, and the fever generally less.

The examination of the tubercle bacillus the author has not been able to execute often enough to be able to fix the result of the treatment in this respect. As to the manner of the injections, it is to be remarked that they are executed best either in quiet breathing, or, best of all, about the end of the expiration. Yes, one shall even try to inject the liquid in the right or left bronchus by turning the syringe to the respective side. The sensation caused by the manipulation is insignificant, so that one can make up to six injections. Sometimes a slight difficulty in breathing takes place. The treatment of injection is especially then of advantage when coughing excretions, with or without hemoptysis, are present, but not too extensive caverns, not too important infiltrations, but also then astonishing results are to be recorded. The duration of the treatment must last in easy cases from four to eight weeks; in more difficult, from two to four months.

If this new therapeutic procedure mentioned and made use of by R. may well be remarked as interesting enough to undergo, on the basis of a methodical examination, a further trial, yet the manner of the proceed-

ing, as preferred by R., must be thoroughly and decidedly refused. The task to be solved before the therapeutic application was, conformably to reason, that to examine if in general something of the injection liquid gets into the lungs, and if this is the case, where the liquid gets to. This proof is entirely wanting, and to denote it as found through the subjective sensation of the patient—that would be imprinting upon the whole method from the beginning the character of a hypothesis.

L. C.

#### Another Case of Short Interval between Confinements.

EDS. MED. AND SURG. REPORTER:—

The case reported by Dr. L. N. Davis, or rather by Dr. I. N. Trent, in your recent issue, page 192, reminds me of one—somewhat similar—in my own experience. My case may not be the shortest on record, although as close to it as it can be, but I think it as of much more interest, from the fact also that four children have been born within three years, at full term, and single births each time.

In looking over my obstetrical record, I find the case is that of Mrs. B., aged 17, whom I delivered for the first time March 5, 1883. In January 8, 1884, I attended her once more in her second confinement. Again in December 31, of the same year, I attended her in her third confinement. Finally, I delivered her again for the fourth time, November 18, 1885, of a fine and only girl. The case is remarkable for the short interval between each confinement, also for the young age of the lady, who at the age of twenty is already the mother of four children. On the other hand, she enjoys good health, has grown stout, and in fact, as I told her, "it seems to agree with her."

J. J. LAMADRID, M. D.

412 Greene Ave., Brooklyn, N. Y.

#### Supernumerary Fingers.

EDS. MED. AND SURG. REPORTER:

On September 8th, 1885, Mrs. S., a colored lady, was delivered of a female child, that was well formed and in every respect natural except the hands, which had an extra finger, or rather part of a finger, on each hand. The attachment was at the union of the first and second phalanges, on the outer surface. The attachment was by a small pedicle, one-eighth of an inch, the other one-fourth of an inch wide. The extra fingers were about one-half inch long, and had a nail and one phalanx on each. I removed

them by clipping the pedicle; one bled considerably, and had to be bandaged to stop it, the other bled but a drop or so.

Upon inquiry I found this to have been the first case in the family, although the mother expected it, and was not surprised at the discovery. She related that her mother, two sisters, and two first cousins, had two supernumerary fingers; one aunt on her mother's side had but one. All were attached at the same point, as near as she could recollect.

J. L. GEYER, M. D.

Norwich, O.

#### Sour Milk in Atonic Dyspepsia.

EDS. MED. AND SURG. REPORTER;

As Dr. W. O'Neill reported a case of atonic dyspepsia (in the REPORTER of January 9) treated with sour milk, and having used it for the past eight years, I thought I would give you my experience. The first time that I ever used it was in 1877, after all other treatment had failed. I prescribed buttermilk and sour milk, one pint at each meal, instead of tea and coffee; and after the use of it for one week, the patient, a woman, felt much better, and I continued the buttermilk for one year, and she has not had a return of the dyspepsia up to the present time. I have since treated over thirty cases with the same result.

G. C. WALLACE, M. D.

Rock Rapids, Iowa.

### NEWS AND MISCELLANY.

#### Early Puberty.

A curious case of early puberty was shown by Mr. Bruce Clarke at the meeting of the Pathological Society of London on January 18th. A large muscular boy, apparently ten or twelve years old, came under treatment on account of bowing of the tibiae due to rickets, and the parents made the astonishing statement that he was born on May 17, 1882, a statement subsequently confirmed by a reference to the birth-certificate preserved at Somerset House. He was three feet eight and a half inches high, and weighed four stone six pounds. There was some down on his cheek, and, though there was no hair on the chest or in the armpits, he was as hairy as a man about the pubes and in the perineum. His penis was as large as a man's, and was noticed to be erect every morning, though the testicles were rather smaller than those of an adult. The pomm Adam was



well developed, and his voice was cracked like that of a boy losing his "childish treble." The development of his brain, however, had not kept pace with the growth of his body, and his mental state was about that of a child of his years. The girth of the head round the occipital and frontal protuberances was twenty-one inches, which is certainly not very small for his bulk. It is interesting to note that, in spite of the great development of his sexual organs, he has never given any evidence of sexual desire, and that no seminal emissions are known to have occurred. The boy was the third child in a family of five, and he was bigger than the eldest child, who was over seven years old. He was suckled for nine months. At about one year of age he began to grow rapidly and to eat voraciously, so that nothing seemed to satisfy him. Hair began to grow on the pubes, and before he was a year and a half old, he was as hairy as a man. At about this time this very rapid rate of growth ceased, and since then his mother thinks he has only grown with ordinary rapidity. Mr. Bruce Clarke performed osteotomy on the bowed tibiae, and the boy made a good recovery. A few cases are on record where puberty developed between the ages of two and three years, but Mr. Clarke informs us that he has been unable to find any other case recorded where it developed before eighteen months of age.

#### A Novel Consultation.

A writer in an exchange says: We were about three miles from Natchez, when we heard a great shouting and wailing in a negro's cabin by the roadside, and it was decided to dismount and go in. It was a tumble-down structure with but a single room, and into this were crowded sixteen or eighteen colored people, mostly of the female sex. On a heap of straw on the clay floor was a sick woman. She was rolling her eyes and writhing as if suffering great pain. When asked what ailed her, an old white-haired negro, who was called "doctor" by the others, replied: "Dat's jist what we doan' agree on. Some says it's de bilyus colic, an' some says it's de gallopin' consumpshun." "Why, man, something ought to be done for her right away." "'Zactly, sah—'zactly, an' Ize de doctah dat would like take right hold ob the case." "But why don't you!" "Kase Ize boxed up, sah. I nebber gin the same medicine fur gallopin' consumpshun dat I do for bilyus colic, an' until we kin decide on de ailment I doan' dare go ahead." We were

on our horses and ready to move off when the old man came out with a happier look on his face and said: "Gem'len, we has sorter took a vote on it, an' we has declared it rheumatism by one majority. Ize gwine right at it to heat de bricks an' gin her an all-night sweat."

#### Uneducated Druggists.

In reference to the necessity for state pharmacy laws in New York, the *Pharmaceutical Record* gives the following telephone conversation:

Central—"Hallo, Central! Give me Dr. B."

Pill-Grinder—"Halloh, Dr. B., is that you?"

Doctor—"Yes; what is it?"

Pill-Grinder—"I have a prescription of yours; have the first article, the second I can make if you are in no hurry, but the last article on it I am sure I cannot get."

Doctor—"Well, what is it? Read it."

Pill-Grinder—"The first article is sulph. morphine."

Doctor—"That's all right; what is next?"

Pill-Grinder—"It reads 'ung. pet.'"

Doctor—"Never mind; take cosmoline."

Pill-Grinder—"But, Doctor, the next article I am sure I cannot get in the city."

Doctor—"Well, go ahead and read it."

Pill-Grinder—"It reads, 'bene admisce.'"

Doctor—"Oh, never mind; just mix it well and thoroughly."

Query—Where is your State Pharmacy Law?

Echo Answers—Where?

#### Succession Duties Claimed on a Surgeon's Fee.

A medical man at Liege having to perform a serious operation on a lady, was asked his fee, and was offered it in advance. This, however, he declined. The result of the operation was unfavorable. After the patient's death the fee was paid by the family without any objection. Some time afterwards the surgeon received a letter from the notary of the Public Revenue Department, stating that the Administration of Finance "declined to recognize the fee, as, considering the position of the patient, it was exorbitant," and demanding succession duty on the whole. He added that if a lawsuit was to be avoided, a detailed circumstantial account must be furnished. The editor of the Belgian medical journal, to whom these particulars have been supplied, says that he never before heard of a revenue officer

claiming to interfere between a medical man and his patient about the amount of the fee.

#### Stauffer's Instruments.

Among the numerous instruments devised for use in gynecological cases, those manufactured of hard rubber by the Stauffer process deserve to attract the attention of physicians by their cleanliness, durability, and adaptation to their purpose. From several recent letters before us we may quote the experience of those who have used them. Dr. D. A. Phillips, of Pa., writes: "The purchase of Stauffer's uterine supporter effected through you has proved to be the most satisfactory one I ever made. The instrument leaves nothing to be desired." Dr. E. Cowan, of Mississippi, says: "The Stauffer belts and cups give universal satisfaction."

A descriptive catalogue, illustrated, will be mailed on application to this office.

#### A Fever Swamp in Africa.

The *Medical Summary* says that Bathurst, on the river Gambia, seems to be a place blessed with any amount of inducements for travelers. Listen to one of them: We have shipwrecks, fevers, ants, ulcers, and malaria, which never fail us. The soil is loaded with it, the ships which visit our coast are loaded with it. Our houses are impregnated with it, and we have it in almost every form, and with every complication, all those known to medical science, besides a host which have yet to be added. Artemus Ward said he was very well satisfied to have his wife's relations go to the war and fight and die for our dearly loved gridiron or flag. We say how happy we should be if our mother-in-law would go to Bathurst. But then it might be hard on the Bathurstians, if any are left in that delightful climate.

#### Preventive Inoculation by a Russian Priest.

From the *Canadian Practitioner* we learn that a Siberian journal states that in 1868, when the plague was killing all the cattle in the country, Father Andrew Joakimansky, of the Troitzky village, resorted to a desperate means in order to save his cows. He got some blood from a dying cow, saturated threads with that blood, and passed these threads through the ears of the healthy cows, numbering eleven. At the place where the ears were punctured there appeared tumors of the size of pigeon-eggs. In a short time these tumors disappeared, and

the cows remained alive and healthy, though the rest of the cattle of that village perished.

#### New Pharmaceutical Preparations.

##### *Hydronaphthol.*

This is one of the same class of organic compounds as phenyl, and possesses similar antiseptic and detergent properties. It promises to have a wide use in surgery and sanitation. An excellent preparation of it is offered by Messrs. Seabury & Johnson, New York.

##### *Hollow Suppositories.*

The experience of every year emphasizes the advantages of rectal medication over any other method in numerous cases. Its details have been vastly facilitated by the invention of hollow suppositories, prepared of pure cacao butter and with self-sealing stoppers. This happy device is the ingenious production of the firm of Hall & Ruckel, 218 Greenwich street, N. Y., who furnish these suppositories in a great variety of forms and sizes.

#### A Tax on Burials.

The health authorities of Newtown, New York, where many of the large cemeteries connected with the city of New York are situated, have decided to refuse a burial permit without the payment of a dollar. The object of this is to raise money for the expenses of the town, as so much land is occupied by the cemeteries that it makes the taxes on other property very high. The undertakers are intending to fight the charge, as they say that it is really a tax upon burials, which the law does not permit. The matter is an interesting one, and not very certain of solution. A test suit will be brought to settle the question.

#### The Extent of Sulphur in Lighting Gas.

Pettenkofer concludes an opinion about the contents of sulphur in lighting gas with the words: "I can therefore pronounce with all precision, that it is, as well from hygienic as from a chemico-technical point of view, without any importance if lighting gas, free of hydrothionic acid, contains 0.2, or 0.5, or even 0.7 sulphur per cubic meter. The consumer of gas has never to expect a profit of this hunt after sulphuret of carbon; him it can only interest that the gas is free of hydrothianic acid, and that it possesses the stipulated power of light."

**Association of Physicians and Pathologists.**

The following circular explains itself:

PHILADELPHIA, February 15, 1886.

DEAR DOCTOR:—

In view of the undoubted advances which have everywhere followed in the different departments of medicine, the formation of special societies devoted to their interests, and in view of the fact that each one of the natural divisions of medicine, except those of general medicine and pathology, is represented in this country by a special society, it has occurred to some members of the profession that a similar Association of Physicians and Pathologists is desirable.

Accordingly, two preliminary meetings were held in New York City on October 10 and December 29, respectively, at which the matter was thoroughly discussed, and, after a general expression of opinion, it was finally decided:

1. To form an Association of Physicians and Pathologists, of which the number of members shall be limited to one hundred (100).

2. To hold an annual meeting in the month of June in the city of Washington.

3. To hold the first meeting on Thursday and Friday, the 16th and 17th of June, 1886, with Dr. Francis Delafield, of New York City, as President.

The undersigned were appointed a committee to notify those who were selected as original members, and we accordingly have the honor to cordially invite you to join this Association, and to take part in the proceedings of the first meeting in Washington, as above stated.

FRANCIS MINOT, Boston (Chairman of the Committee).

WILLIAM H. DRAPER, New York City.

WILLIAM PEPPER, Philadelphia.

R. PALMER HOWARD, Montreal, Canada.

ALFRED L. LOOMIS, New York City.

WILLIAM H. WELCH, Baltimore, Md.

FRANCIS DELAFIELD, New York City.

JAMES TYSON, 1506 Spruce St., Philad'a,  
Sec'y of the Committee, to whom it is requested that you will send your answer.

**Snake-bites and Rabies.**

The *Lancet*, January 16, tells us that the curious local traditions that are handed down from one generation to another are sometimes of much interest, and especially those bearing on the treatment of snake-bites and other accidental occurrences likely

to prove fatal. In some of the heath countries a general notion prevails that the bite of a yellow or black adder is best combated by the rubbing in of some of the fat of an adder, and also by giving some of the grease internally. A lay correspondent, referring to an article in last week's *Lancet* by Surgeon-Major Roy, suggesting that the poison of the cobra may prove to be an antidote for rabies, says that it is a curious fact that in Wales there is a belief among the common people that a dog that has been bitten by an adder will never be subject to hydrophobia. When Sir Thomas Watson was asked his opinion on this subject, he said: "I agree with you in inability to see how this could be proved; or how, if proved, it could be practically utilized for the benefit of the human animal; such traditions are, however, always worth preserving." In the course of a case tried before the Tribunal of Correctional Police in Paris, it appeared that the carcass of a dog that had been slaughtered on account of rabies was thrown by scavengers on to a dust-heap, where it was devoured by cats and rats. A great number of the cats in the neighborhood of the places where the dust is shot from the municipal carts have been attacked with rabies.

**Cider and Rheumatism.**

The question has been several times discussed as to a supposed antagonism between the use of cider and rheumatism. Apropos of the question, Dr. T. Reuel Atkinson thus writes to the *Brit. Med. Jour.*:

Having lived for the last three years in this cider-drinking county *par excellence*, will you allow me to say that, in my opinion, instead of there being any antagonism between cider and rheumatism, I am inclined to think that the one has a tendency, if anything, to cause the other. At any rate, rheumatism is, in this neighborhood, in one or other of its many varieties, a very common complaint; and the amount of cider consumed by the British workman about here is, especially in hot weather, something fabulous; many a man drinking his three or four gallons a day, and thinking nothing of it. Apropos of this matter, I have just come upon a passage taken from an old author who, writing of Herefordshire cider, says, after extolling its many virtues: "Lastly, for it excites the appetite, clears the stomach, strengthens the digestion, frees the kidneys from gravel and the bladder from stone. That which is made from pippins, duly ripened and well fermented, is an excellent remedy for consump-

tion." So it is very evident that cider is a remedy not to be despised, although not to be found in the British Pharmacopœia.

**Railroad and Steamboat Fares to the American Medical Association Meeting at St. Louis.**

The St. Louis Association of General Passenger and Ticket Agents, representing the railroads terminating at St. Louis, have announced that the tickets to the American Medical Association meeting, on May 4th, will be sold at the rate of one and one-third full fare for the round trip. The roads represented in the Association are Chicago, Burlington, and Quincy; Diamond Joe Line; Indianapolis and St. Louis; Louisville, Evansville, and St. Louis; Louisville and Nashville; Missouri Pacific; Ohio and Mississippi; St. Louis and Cairo Short Line; St. Louis and San Francisco; St. Louis, Keokuk, and Northwestern; St. Louis, Iron Mountain, and Southern; St. Louis and St. Paul Packet; Vandalia Line; Wabash, St. Louis, and Pacific.

The other railroads of the country have not as yet taken official action in the matter, but we are assured of the same rate being quoted by the majority.

**Items.**

—"Death from exposure," was the verdict recently rendered by a Helena (M. T.) jury on the body of a horse-thief who had been hanged by vigilantes.

—A letter from Berlin to the *Therapeutic Gazette* reports the case of a girl of eight with gonorrhœal rheumatism, communicated by connection with a boy of twelve.

—In our recent notice of the *St. Louis Medical Journal*, we should have added that Dr. Ohmann Dumesnil continues to be associated with its editorial supervision.

—"Ain't it time you paid me that five dollars?" "Tain't due." "But you promised to pay me when you got back from New York." "Well, I hain't been there yet."

—Dr. Geo. H. Gilson, of Ills., writes us that on the 25th of January he delivered a colored girl, thirteen years of age, of twins, and that both mother and children survived.

—Mr. Sutro, of California, is about to build an aquarium 120 feet in diameter in the Bay of San Francisco. It will contain every sort of sea anemone, mosses, and shell-fish.

—The English language consists of about

38,000 words, yet when a man is pulling on a tight boot or waiting for his wife to dress, he nearly always invents a few extra words to express his feelings.

—"What are the last teeth that come?" asked a Lynn teacher of her class in physiology.

"False teeth, mum," replied a boy who had just waked up on the back seat.

—Dr. N. Roe Bradner has established at Burlington, N. J., a private villa for the care of insane patients and others requiring quiet and medical supervision. We take pleasure in recommending Dr. Bradner's institution.

—A lunatic who escaped from the Hospital for the Insane at Buffalo two years ago, and has since been wandering over France and Great Britain, returned to his home in New York the other day perfectly cured, it is reported.

—Professor Semmola, of Naples, has received from the King of Italy the gold medal of "Public Merit," in recognition of his zeal and devotion in directing the sanitary service of the White Cross during the cholera epidemic of 1884.

—It is said that glycerine in its pure state should not be used for chapped hands, as it absorbs moisture from the skin, thus leaving it dry and liable to crack. When moderately diluted with water, however, glycerine is an excellent application.

—There is nothing new after all in the Pasteur method. It has been long known and tried in communities where it is the custom in the morning for a man to inoculate himself with a thimbleful of the dog that had bitten him the night before.

—A Montreal man lately sued a druggist for damage for having been deprived of work for several weeks in consequence of taking a poison sold him by mistake. The error was caused by the wholesaler, who had labeled the package wrongly before selling it to the druggist. The Court held, however, that the druggist should have verified the contents of the package, and gave judgment for \$200 and costs.

—A Chicago firm is engaged in making bricks out of a mixture of sawdust and clay. They are subjected to a heavy pressure, burned like common brick, and in some way made waterproof. They measure 13 by 6 by 4 inches, and having two square holes running through them lengthwise, they weigh little more than common brick, although four times as large. They are laid between the outer and inner courses of a wall.